South West Care Homes Limited

Ashfield

Inspection report

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Date of inspection visit:
10 June 2019
11 June 2019
27 June 2019

Date of publication:
06 September 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Ashfield provides accommodation and personal care for a maximum of 25 older people. Some people who use the service are affected by dementia or physical frailty. The service does not provide nursing care. People who live at Ashfield access healthcare through the local community health team. Ashfield is owned by South West Care Homes Limited. The company operates a total of nine care homes in the South West. At the time of our visit there were 18 people living at the home.

Ashfield 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.

People's experience of using this service:
We last inspected Ashfield in November 2018 when we rated the service as 'Requires Improvement' in the key questions of safe and well led. This was because although the service had identified many of the issues we found, we could not be assured actions they told us they were planning to take would be effective at resolving the issues, as they were not yet in place. We found concerns relating to safeguarding referrals, inaccurate risk assessments and lack of robust environmental risk assessments. We made a breach of Regulation 15 HSCA RA Regulations 2014 Premises and equipment. We also recommended the provider sought and followed best practice guidance on the adaptation of the premises to meet the needs of people living with dementia. We also recommended the service took advice on the provision of person-centred activities that meet people's interests, wishes and choices, including the implementation of activities for people living with dementia.

At this inspection we found the action taken had not been sufficient to address the improvements needed and the service rating has deteriorated to inadequate.

At this inspection in June 2019, there continued to be no registered manager at the home with the current manager leaving. On the third day of the inspection a new manager was managing the service following a period of management induction and continuing support. There was a lack of consistent management oversight and governance of the service. Despite visits from the area manager, quality assurance systems were not effective, and staff did not feel involved or listened to. Audit systems had not identified all areas for improvement such as environmental and safeguarding risks, adequate staffing deployment and management and lack of effective fall, behaviours, continence and pressure care management.

We also found our two recommendations had not been followed resulting in a lack of stimulation and social activity for people and a lack of dementia care provision.

Staff had some understanding of how to support people to keep them safe but did not always follow care plans or safe practice to ensure people received care safely consistently. The management of behaviours which could be challenging to others, continence and pressure care were not managed well as there was no

consistent or regular checking to ensure these areas were addressed to keep people safe. The provider had not ensured safeguarding procedures were always followed to keep people safe, for example identifying incidents as safeguarding issues.

People with complex needs such as those who were partially sighted, lived with mental health issues or dementia did not always have their needs effectively managed.

Staffing deployment and management meant there was limited time for staff to support people with activities and there was limited social interaction unless for tasks. Communal areas were not laid out to be inclusive and comfortable.

Infection control and maintenance was not well managed. There were odorous areas and furniture due to poor continence management. There was no overall robust maintenance programme to ensure timely actions were taken to keep the premises clean, well maintained or safe for people.

People received enough to eat and drink but there was a lack of people's involvement in menu choices and sometimes morning or afternoon drinks were not offered.

Staff had been recruited safely and completed an induction when they first started.

Medicines were well managed.

Rating at last inspection: At the last inspection the service was rated as requires improvement. The last report was published on 7 February 2019. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made/ sustained and the provider was still in breach of regulations.

Why we inspected:
The inspection was prompted in part due to concerns received about the lack of activities and social stimulation. A decision was made for us to inspect and examine those risks.

Enforcement: We have identified six breaches in relation to; safeguarding, falls, continence and pressure care management, staffing deployment and management, premises (health and safety and maintenance) and lack of dementia care adaptations, person centred care and communication needs, notifications and overall governance.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

After the inspection
We met with the provider and area manager to gain assurances that our concerns were being addressed as a matter of urgency. We asked for weekly staff rota reports and an environmental risk assessment, which we received. The suitable checks of the environment and equipment were in place and actions were being taken. We also made a safeguarding alert to the local authority about our concerns.

Since the above actions were taken the provider has told us they continue to address all the areas of concern. We attended the whole service safeguarding meeting with the local authority and this process continues. The provider has agreed a voluntary suspension on new placements. The local authority will be reviewing some people at the home. Community nurses will be visiting the home to ensure concerns are being addressed. We continue to hold corporate provider meetings where the provider has told us about the positive changes they are making. There is a newly appointed quality assurance team starting in September and the new manager assured us they were addressing the concerns at Ashfield. For example, additional care workers have been recruited and cook hours increased, a deep clean completed, continence management has been improved, communal areas changed and an activity co-ordinator is being sourced. Work identified in the environment risk assessment has been commenced. The provider is also carrying out weekly visits to the home to support the new manager.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Action we told provider to take (refer to end of full report).

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Ashfield

Detailed findings

Background to this inspection

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

This inspection took place on 10, 11 and 27 June 2019 and was unannounced.

This inspection was carried out by an adult social care inspector on all three days and an inspection manager on the second day.

We did not request that the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We had received one at the previous inspection in November 2018.

The service had not had a manager registered with the Care Quality Commission for 108 days. When registered this means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

We reviewed the information that we had about the service including safeguarding records and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who lived at the home were unable to verbally express their views to us, we therefore observed care practices in communal areas and saw lunch being served in all areas of the home.

During the inspection we spoke or spent time with 16 people who lived at the home. We spoke with the manager at the time of the first and second days of inspection and the new manager on the third day. We spoke with two team leaders and six care workers, the cook, two domestics and the maintenance person. We also met with the area manager. We met with three relatives/ friends of people who were using the service and spoke to one visitor on the telephone.

We looked at a number of records relating to individual care and the running of the home. These included five care plans, medication records, three staff personnel files, minutes of meetings and records relating to quality assurance.

After the inspection
We met with the provider and operations manager to gain assurances that our concerns were being addressed as a matter of urgency. We asked for weekly staff rota reports and an environmental risk assessment, which we received. The suitable checks of the environment and equipment were in place and actions were being taken. We also made a safeguarding alert to the local authority about our concerns and in particular the care relating to one person. We then made a referral to the fire prevention service as we were concerned about fire safety of the premises. The fire officer visited the service on 12 August and was able to confirm that the service was safe.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to manage concerns had not always been followed to ensure, where appropriate, investigations took place. At the last inspection we asked the previous manager to make a safeguarding referral because timely medical assistance had not been sought following a fall. At this inspection a GP had not been called following a fall. The team leader said they had forgotten as they had been so busy. They had made a safeguarding referral in error about the GP not attending which was not the case as they had not been called.
- Some people living with dementia also displayed behaviours which could be challenging for staff and put people at risk of harm. The incident reports showed ten incidents in January 2019, nine in February and 13 in March including people shouting and hitting each other. There was no audit or oversight of these incidents. We also found examples of where incidents had not been highlighted on the report as they were only recorded in daily records and handover report. For example, one person had thrown hot tea. The record said, "during this episode they hurt others and they were told not to do it" and "keeps throwing papers and drinks from first to ground floor". There was no care plan about how to manage behaviours or preventative action taken.
- We had only received three notifications of incidents relating to safeguarding in 2019, two in April and one in May. Two incidents recorded on the incident report said people had pushed another and at another time punched a visiting activity person in May 2019. Actions were telling the people 'not to do it again' despite them living with dementia. There was no evidence of referrals made to the local authority safeguarding team. Staff said, "It's very upsetting. [Person's name] is a good example as she is often rude and aggressive, banging their frame at people as they are protective over the television. They would be happy if they were crafting, which they like." This person sat in a dining room chair all day on all three days of our inspection, not engaged in any activity.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding people from the risk of harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Although care plans were detailed and included good risk assessments, these were not always followed robustly to ensure checks were being done. For example, checks for people in their rooms who could not use the call bell and regular re-positioning for people at risk of pressure damage were not consistent, which put people at risk.
- Falls management was dealt with individually but there was no overview or audit of falls to ensure any

patterns were identified to minimise any further ongoing risks.
● All staff spoken to said the home did not use bed rails but wedges. This was not the home's policy as there was a bed rail assessment to use. One person had fallen out of bed whilst using the wedge so it was unclear what preventative equipment staff should use.
● There were 13 recorded falls in January 2019, nine in February and seven in March. Most were unwitnessed by staff and happened in all areas of the home. Most people were at risk of falls as well as living with dementia. Some people were able to be mobile meaning they required supervision when mobilising. These had not been analysed to identify if there were trends or patterns in the occurrence of falls.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

● People had Personal Emergency Evacuation Plans (PEEPS) so staff and emergency services knew what level of support people required in the event of an emergency evacuation.

Staffing and recruitment
● The way staff were deployed meant that peoples' needs were not always met and they were not always kept safe. For example, to ensure people at high risk of falls were supervised. There was a lack of staff presence in the lounge for long periods whilst the three care workers and team leader were busy assisting others. The home had three floors and two wings. There was no evidence the eleven people who could not use a call bell in their rooms were checked regularly, other than at night. These care plans said, people required hourly checks at all times. One person lay curled up on their bed all day on the third day. Another person who sat outside was not checked regularly. There was a lack of interactions between people and staff unless for tasks such as meals and no evidence of any activities other than weekly external entertainers.

● Staff deployment meant that care staff were expected to do the laundry, assist in the kitchen with afternoon tea after the cook left at 2pm, sometimes assist with cleaning following an incident if it occurred after the domestics left at 1pm and to provide activities. Staff all said there was 'just not enough staff' to meet people's needs. At times they said there was only a team leader and two care workers on duty at the weekend. This was not reflected in staff rotas, for example rotas showed what staff were expected but not how many staff were actually on duty. The dependency tool stated there were enough staff but had not been completed to take into account of these other tasks or reflect properly the actual needs of the people. For example, eight people required assistance with continence management, four people required assistance with eating and drinking and five people needed two care workers to mobilise. During the inspection a care worker was often in the kitchen helping the cook which meant one less care worker 'on the floor'.
● The cook had worked 16 days in a row over Easter and staff spoke of "two weeks of hell" due to lack of staff.

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

● Recruitment of staff followed best practice guidance. Checks to ensure new staff were suitable to work with vulnerable adults were completed before staff commenced working at Ashfield.

Preventing and controlling infection
● Staff completed training on the control and prevention of infection and understood the need to use gloves and aprons, but good practice was not always followed. Hygiene and cleanliness in relation to continence

management was poor. There was a low odour of urine throughout the home, particularly noticeable on the third day. Two people were sat on wet arm chairs and a dining chair. These had not been cleaned thoroughly before people sat in them again and smelt.

● Cleanliness was not of a good standard, especially in the afternoons. Some staff were particularly upset because they felt they could not do a good job. Domestics worked mornings until 1pm and were supposed to deep clean two rooms a day, this was not happening. They said they could not clean people's rooms to a good standard because they spent their time cleaning up after continence accidents. Their daily washroom check list for example, showed how bathrooms and toilets were cleaned repeatedly two or three times in a morning. They told us how one person who was living with dementia put items in a toilet including faeces. Another person urinated all over the home constantly and this took up a lot of time. The domestics now kept the 'wet floor' warning sign up all the time but said when they couldn't get there in time people were walking urine around the home. The corridor carpet smelt.

● There was no record of deep cleaning once rooms became empty. Domestics said they had never seen any deep cleaning. The new manager on the third day had recognised this and arranged for a full home deep clean.

● There was no equipment cleaning rota in place so items such as hoists needed a clean.

● People had pressure cushions to relieve the pressure on their skin and help prevent sore areas developing. These were not named to help ensure they were used by the same person to minimise the risk of any spread of infection. We saw one cushion being quickly wiped down with a cloth before the person who had been incontinent sat back on it.

● Soiled laundry items were left in the laundry baskets in the laundry for most of the day periods. Staff said they did not always have time to ensure washing was done in a timely way as they had to do it between them in the day.

● At least four commode pans were dirty, stained and odorous in people's rooms, which we showed the new manager. There was no sluice area and staff had no easy access to cleaning equipment for people's rooms. Staff said they rinsed them out with water.

● Not all risks to people from the environment had been identified, or actions taken to address them in a timely way. There was no overall environmental risk assessment. Maintenance was managed by staff listing small issues for the maintenance man who only worked 18 hours a week. Completion dates were not recorded. They had another handwritten list they were sending to the provider, also noting they had to use their own tools. Staff said things took a long time to complete and the manager who was leaving wasn't sure of who was responsible. For example, the dishwasher had not been adequate for nearly a year and a COSHH cupboard was not available in the kitchen. This meant time was spent manually washing up and going to the basement to get cleaning materials. Staff said they had told managers in the past of their concerns.

● We asked the fire prevention service to complete a fire report as we were concerned about the fire safety of the premises at the time of the inspection. The fire officer visited the service on 12 August and was able to confirm the service was safe.

● There were issues during the inspection in most bedrooms ranging from tired décor, old dispenser holders on the walls, peeled wallpaper, shabby wooden doors, unsafe door guards and old furniture. Some ceilings had holes, some wall cracks needed attention. There were uneven curtain poles and old, dirty carpets in some areas. There were no regular call bell checks. Rooms did not feel looked after or homely for people.

● The top staircase to the staff flat from the second floor was steep and accessible. This was a risk to people especially those living on the second floor who were mobile.

● The laundry area had flaking paint on the window frames and sill and in the cupboard making it impossible to clean. At the last inspection we also found issues relating to the laundry room.

● There were copious cigarette butts outside on the floor where one person smoked.

●One relative said, "Health and safety is a nightmare".

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and Equipment with additional concerns found.

Using medicines safely

● Medicines were received, stored, administered and disposed of safely. Staff who gave people their medicines had been trained in safe medicines management. The team leader responsible for medicines management was very knowledgeable in this area. They ensured staff were competent and wore the 'do not disturb' tabard. Records were complete and ensured safe medicine management.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before admission, to identify if the service could meet their needs. However, despite these assessments they had failed to identify whether there were enough staff to meet people's complex needs and we found people's needs were not always met safely and effectively at the home. For example, behaviours which could be challenging for staff and complex continence management.
- Continence management was poor. One person had complex needs relating to behaviour. They had no activity or social stimulation other than in passing and continued to urinate throughout the home, telling us they were bored. Staff said they did not have time to support their continence needs and reacted once the person was soiled. Staff said they mostly carried out pad changes rather than support people to the toilet. A staff member said they had never seen staff taking the person to the toilet. They were soiled three times within half an hour. Staff said the person drank too much but there was no plan of how to manage care.
- Care task alerts on staff phone systems did not always include regular checks assisting people to the toilet. Another person was found sat in a wet chair on the morning of the third day. The care plan alerts were only at 11.30am and 4.30pm. Eight people were unable to call for assistance relating to continence management and relied on staff input. Care records mainly showed pad changes and that people were already wet when staff went to them. One person's daily records about toileting said the person was wet each time staff saw them.
- The management of pressure care was not robust. Although the staff phone system showed turning/repositioning charts, these had not been audited. They showed one person at high risk who was supported in bed. They preferred to only lie on their back, meaning moving position was more important to maintain skin integrity. Their chart showed multiple long gaps between re-positioning. This put them at risk of developing pressure ulcers.
- Bowel management was also inconsistent with few records about people's bowel habits. One person's daily records showed they had had their bowels open, the note said, "Entirely liquid, was content." Staff had not followed this up.
- Care plans contained some good information about people's needs and choices to support staff in delivering care in line with the required standards. However, people's needs were not always being met. For example, although recognising one person lived with obsessive compulsive disorder (OCD), there was no specific care plan about this. The person spent the whole day on all three days, worrying about their bed being made, going up and down to their room, with no staff addressing their concerns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Adapting service, design, decoration to meet people's needs

● The communal areas were not arranged to be homely, comfortable places for people. There were two lounges on either side of the entrance hall. Both had minimal easy chairs, four in one lounge and space for five people in another. The only other seating was at the dining table for six, one in each room.

● One lounge was used by two people only throughout the inspection. The lounge near the kitchen with the television on was noisy, a thoroughfare with staff passing. The television was low set and there were often people or staff standing in front of it.

● There were few adaptations for people living with dementia. Bedroom doors had no identification to promote independence. There were some signs for the toilets and lounge in pictorial form but little else to engage or stimulate people. Staff knew that people were bored, saying this triggered negative behaviours but people were not encouraged to move or use the garden despite the sunny weather. The garden and outside were not easily accessible for people independently and they relied on staff. Some people's care plans said they enjoyed helping staff. We only saw one example of how a person had enjoyed doing some chores.

● There had been no assessments to determine how the environment could better support those people living with dementia or who were registered blind at the home. This was despite discussion in the local authority quality assurance team (QAIT) report in January 2019 and in our November 2018 inspection report.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Premises and equipment

Staff support: induction, training, skills and experience

● The manager in place on the first two days of the inspection had ensured staff were up to date with training. This was self directed using DVDs and a workbook. The manager said there hadn't been any external training. Staff received an induction when they started work. Staff told us they completed an induction to the service which included a tour of the building and learning about procedures related to people's health and safety. They also worked alongside other experienced staff, so they knew how to support people's needs appropriately. However, there continued to be a lack of safeguarding incident reporting, poor falls, pressure care and continence management.

● Some staff had received supervision meetings with the manager to discuss their training and any developmental needs. The new manager had booked in other staff to get supervisions and appraisals up to date.

Supporting people to eat and drink enough to maintain a balanced diet

● Although people said the food was nice, ineffective management and staff deployment and lack of organisation meant meal times were not a positive social event. Few people ate at the two dining tables, one was situated in each lounge. The tables were bare and unlaid and there was no menu for people to see. Most people ate where they were sat all day or in their rooms. Although people seemed to enjoy the food and fluid charts showed they had had enough to drink, staff and the cook said they were too busy. This meant they sometimes had to do a simpler tea menu different to the menu rota so it was easier for afternoon staff to prepare. Staff also said the morning tea and coffee rounds were not always done. The cook liked to make homemade cakes but did not always have time.

● People at risk of malnutrition and dehydration from not eating and drinking enough, had been referred to a dietician/GP for advice on how to manage this risk. The cook and staff knew about people's special

dietary needs and said they took these into account when preparing meals.
● A staff member said the menu had not, however, been devised based on people's likes and preferences but on what was easy for staff to prepare after 2pm.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Staff sought people's consent before providing support. If people indicated they did not want a bath for example or declined personal care, staff returned later. However, daily records showed an example where a care worker had taken away a person's wheelchair in the garden to prevent the person moving unaided. This had triggered an abusive response from the person rather than managing the prevention of falls in another way.
● The manager understood their responsibilities under DoLS and there were applications to the relevant authority for authorisation to deprive people of their liberty where they considered this was appropriate. However, one person's care plan said they regularly tried to 'get out'. Staff had not considered whether the person would actually like to go out. There was no plan about how to manage their desire to go out other than a DoLS application to restrict them leaving.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records showed people accessed health professionals when needed to support them with their dental, optician and chiropody needs to maintain their health.
● People saw dieticians, district nurses and speech and language therapists who advised staff how risks associated with people's health should be managed. For example, they followed speech and language team (SALT) advice about using drink thickener for some people to reduce the risk of choking.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity ; Respecting and promoting people's privacy, dignity and independence

- Although people spoke positively about the staff, we found people's privacy and dignity was not always respected. People were seen with spills and stains on their clothes, which showed a lack of attention to detail and care.
- Because there was inconsistent continence management, some people were sat with wet continence aids or left to be incontinent in chairs or around the home.
- Staff were unable to manage one person with complex continence needs. This person on all three days had periods where they walked around the home with their trousers falling down and continence aid hanging out. There were no preventative measures in place and staff reacted if they were nearby, but at times they were not in the same area. The person said they were, "Very bored."
- Although care plans included good information about people, this was not being used to inform how they received their care. For example, staff did not sit and talk to people in a meaningful way, spend time with them or ensure they had regular checks in their rooms. A person receiving end of life support was regularly re-postioned but then left alone for the rest of the time. One person said they were "fed up of it all". They sat alone outside all day for all three days.
- Staff when interacting with people were kind and gentle. They aimed to support people's varying needs but did not always tell people who were partially sighted what was going on around them so they did not become anxious. For example, although the care plan said they liked to listen to the television, the room was too noisy and they were not asked what they would like to listen to.
- Staff were too busy to ensure people's rooms were kept clean and tidy in the afternoons. One care worker said, "No cleaning today". The domestic said, "It's not like a home, we can't keep it clean."
- People's behaviours that could be challenging for others were not well managed, meaning some people had to endure ongoing negative interactions with others which could be distressing. Behaviour management of recorded incidents showed staff only told people 'not to do it again' despite people living with communication/comprehension difficulties.
- Two relatives said that the care could not be faulted, and that it was second to none. They added, nothing was too much trouble for the staff.

Supporting people to express their views and be involved in making decisions about their care

- Although a quality assurance survey for people and health professionals had been given out in 2018 there

was no overview or action plan about comments. We could not see any surveys sent out to relatives.

● People said they were not asked anything about the home or what they wanted to see happen. There were no recent residents' meetings. The cook said the manager leaving had recently started a two choice menu from one choice. However, this was not based on people's choices but what was easier to make and for staff to manage for tea time after 2pm when the cook left.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate.

Inadequate: This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● At our last inspection, we identified people had opportunities to participate in some external activities, but staff were not able to respond to people's individual needs to socialise or enjoy leisure activities. We noted, the registered manager told us they were moving towards having more person-centred activities taking place, in line with people's needs and wishes. This had not yet translated into consistent practice. We made a recommendation at that time for the service to take advice on the provision of person centred activities that meet people's interests, wishes and choices, including the implementation of activities for people living with dementia. At this inspection we found people spent the day sitting doing nothing or walking about the home. Staff were expected to provide activities but they said they did not have time or they were not encouraged to spend time with people. There was no designated activity co-ordinator. Staff comments included, "It would be a nicer home if we could spend time with people", "I feel awful seeing people do nothing all day" and "I grabbed a kitchen cloth to give to one person. People want to help but no-one can do it."

● One visitor said " They seem to bring them and plonk them down (in the lounges)".

● The home was very bare, there were no items to engage people with and the lounge was too noisy for people to be able to watch the television, especially as the lounge was a thoroughfare. People tended to walk about unsupervised or gather at the kitchen serving hatch. The cook said they sometimes felt upset as they had to shut the hatch as people wanted to talk and they needed to get on with work. Activity records mainly showed hairdresser and chat with staff which we only saw in relation to other tasks. The team leader daily check lists were mainly blank for 'activities documented'.

● People told us they were bored. On all three days three people sat all day on the dining chairs in the lounge. All lived with dementia and were unable to understand each other. One person said, "I live for meal times and it's only ten o clock". They stayed in their room all day saying there was nothing to do. Two people who were friends said, "We would be lost without the television and each other. Nothing else to do". The second day of our inspection they both said, "Same again today." One person walked around the home constantly on all three days. They said, "I'm bored, there's nothing to do." Another person with a history of regular negative behaviours told us, "I'm just going to sit on my bum again today." One person's care plan said they liked to be busy by helping tidy up, set tables and other domestic tasks. This was not happening. Previous quality assurance surveys had mentioned a lack of activities and outings in 2018.

● The service user guide in people's rooms stated there was a key worker system so people had a named care worker. It said, "They could take you down to town, have a cream tea and coffee, play games or spend time just chatting." This was not happening.

● People's care plans gave information about what people liked such as , "Love music and will dance and sing to anything. Enjoys outings and likes to go out in the fresh air." This was not happening. One person was identified as living with depression and anxiety but there was no care plan as to how to support this and daily records did not mention this. Their daily records stated, "Unsettled and confused, wandering round a lot, unsettled getting up, tearful." A note said the person was more settled with singing but this was also not happening or recorded. Another person with depression and paranoia sat all day, each day of our inspection, on a dining chair doing no activity. They were known to tell others what to do and could be negative. This was upsetting for the two people they were sat with. Their behaviour plan said, "Listen to their stories and show an interest, reassure and watch musicals." This was not happening.
● A visitor told us on our share your experience webform, "The care home isn't caring properly for the mental state of the residents. Residents are left to wander with little interaction. The care home provides basic needs. Residents are left in their room without interacting with others. It's a dumping ground for our elderly."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Most people were living with dementia or other mental health related conditions. This meant people were identified as having triggers to negative behaviours. However, where care plans noted that people had anxieties, paranoia or OCD but we did not see staff putting actions into practice or records showing how this was managed. For example, plans stated how their dementia may affect them and that people needed to be kept busy, reassured or occupied with activities they liked as distraction but this was not happening.
● One person was partially sighted; the care plan said they liked to listen to the television. The lounge was very noisy. They could not hear or see the television and staff did not tell the person what was in front of them when giving drinks or food.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person centred care

Improving care quality in response to complaints or concerns
● There was a complaints procedure available to people if they needed to raise any concerns. We saw one complaint about how a person was always in their room. The complaint had been addressed and the person was now in the lounge. However, one relative told us they had tried to address the lack of activities by suggesting things for people to do but nothing had happened.

End of life care and support
● People were supported to remain in the home at the end of their life if this was their wish. People had end of life information in their care plans including treatment escalation plans (TEP). Staff had ensured that the family and GP were aware and that the person was comfortable. One person was receiving end of life care although apart from regular re-positioning to minimise risk of pressure damage, they were left alone all day.
● Two relatives were very complimentary about the end of life care their family had received. They added, "We had a mattress on the floor so we could lie with her. [Care worker's name], her shift finished at 8pm, and she stayed till 11pm, talking to us when she was poorly. A staff member was with her when she passed".

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

Inadequate: This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● At our last inspection in November 2018 we identified a number of issues needing improvement. We identified concerns over the premises such as the laundry, fire exits, an electric radiator, and complaints management. We made good practice recommendations in relation to adaptation of the premises to meet people's needs, medicines, and the provision of person-centred activities that met people's interests, wishes and choices. We continue to have concerns about most of these areas during this current inspection and additional concerns.

● Care delivery was not person centred because staff deployment and management did not promote time to spend with people or meet their needs fully.

● People were put at risk of falls, poor continence and pressure care management and lack of supervision.

● People did not have a good quality of life because meal times were not positive social occasions, menus were not related to people's preferences and there was a profound lack of activities and stimulation.

● The provider and management team had not recognised that some of the needs of people were not being met due to poor staff deployment and organisation or listened to staff about what it was like working at Ashfield. They were not spoken to during regular management team quality assurance visits.

● Changes in managers and lack of management team oversight meant improvements had not been made or actions sustained despite this being known. This meant the service did not always run safely and effectively. For example, lack of environmental, falls and incidents risk oversight. There continued to be no registered manager in post, although a new manager had started at the service by the third day of our inspection following a management induction period.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● There was a lack of effective oversight and governance of the service. For example, there was no environmental up to date risk overview. Some maintenance issues were shared with the maintenance man but there was no record of when work was completed other than a tick. The manager emailed the provider or the two senior management managers but found actions to be slow. For example, an environmental health report in July 2018 stated a quote about asbestos management survey was being sought. No further action had been taken. Copious paper archives had been asked to be removed from the basement storage as they were a fire hazard in March 2019 but the manager was still chasing a response. We asked for a robust

environmental risk assessment to be completed as soon as possible, which we received. This showed many jobs which needed completing to make the home comfortable, safe and homely for people, which we had also noted.

● There was no falls or behaviour plan audits or overview to ensure staff were meeting people's needs to keep them safe and using preventative measures. Therefore incidents and falls continued to occur.

● Although there were staff team meetings issues were not followed through such as a discussion about ensuring staff were aware of any potential risks about safeguarding. There were plans to develop and plant the back garden in September 2018. Meeting minutes said, "Please try to get the residents involved". This had not happened and flower beds were empty. Staff keyworker and champion schemes in various topics had not been developed.

● We made a recommendation about the lack of meaningful activities at the last inspection in November 2018. The local authority Quality and Improvement Team (QAIT) report in January 2019 also mentioned plans to improve activities with reminiscence ideas to promote discussions between staff and people living at Ashfield. Ideas were discussed about improving the environment for people living with dementia such as clear door signage for bedrooms. This had not happened. One toilet was out of order but still had a toilet picture on it so people were seen trying to pull the locked door open.

● There was a quality assurance process in place. Each month the manager completed and sent to the area manager, an audit including the number of falls, pressure ulcers, anyone at risk and the actions they would be taking to address any concerns. This would then be monitored by the management team. The management team visited the home at least three monthly and looked at a number of areas, including speaking to two or three people and looking at some care records. This system had not been effective in identifying all the concerns found during this inspection and therefore no actions to address staffing levels and deployment, falls oversight, continence issues and the environment. Therefore, effective actions had not always been taken. Staff said they had never been spoken to by the area manager to seek their views.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● A health professional' satisfaction survey had been last sent out in March 2018. However, this showed out of five questionnaires returned, there were 11 responses rated as poor or average. One person had commented, "Shopping trips or outings for residents could improve". There was no analysis or action plan relating to the findings.

● Quality of service questionnaires had been sent out to people using the service in June 2018. However, staff said these were all completed by the previous manager and the handwriting was all the same. There was no oversight despite comments such as, "I would like to go out more." This person told us they had still not been out. Another had said about activities, "I think something is missing."

● The previous manager had told (QAIT) in January 2019 that they would try and hold resident and family meetings on a regular basis. This had not happened. They had also had an idea of a manager's surgery with a morning a month allocated for 'drop in' for people to talk about any issues. This had not happened. One relative said they had not known of a relatives' meeting in two and a half years.

● There was no evidence of any community involvement for people other than a regular Holy Communion and minimal external entertainment sessions. Most people were local and some spoke to us about their lives in the area. However, most said they had not been out or in the garden since living at the home.

Continuous learning and improving care

● The manager leaving said they had not felt supported although the area manager and provider said this was not the case.

● The manager leaving said they had not had a good handover from the previous manager. They had not seen the last inspection report although this was publicly available or the QAIT report to be able to address

the issues raised.
● Staff said they did not feel listened to or thanked for work done. They said lots of people were leaving due to lack of staff and staff not sourced to cover gaps. One care worker said, "It was awful one weekend with only three of us. One person died, and it was awful. Management knew there was a lot of annual leave booked in advance."
● Staff did not feel safe and said they were often pushed by people living with dementia or cognition difficulties. Behaviour management was poor.
● Following the inspection we asked for weekly staff rota numbers which we continue to receive. This was to assure us there were enough staff to meet people's needs. The new manager was also recruiting new staff.

These shortfalls demonstrate a breach of Regulation 17 of regulation 17 of the HSCA (Regulated Activities) Regulations 2014 - Good governance.

● Registered providers and registered managers have a legal responsibility to inform us (CQC) about any significant events that occur in the home including any serious injuries or safeguarding events. The provider had failed to ensure this had happened for at least one safeguarding incidents that had occurred. The incident in the daily records for one person said, 'harmful to others' and the person had thrown hot tea. There was no behaviour plan monitoring. We were told about people displaying behaviours that could be challenging to others but we could not be confident these were identified or recorded consistently. Notifications about safeguarding issues had not all been referred appropriately to the local safeguarding team either.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4): Notification of other incidents

Working in partnership with others
● We saw evidence of staff referring people to health professionals in a timely way. For example, monitoring urinary tract infections and small wounds. Community nurses visited the home when needed. For example, an occupational therapist assessment had resulted in one person obtaining the equipment they needed to mobilise more independently.

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 18 Registration Regulations 2009 Notifications of other incidents Safeguarding incidents were not always identified and required reporting processes were not always followed to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always kept safe as risk assessments and actions taken were not robust. For example, falls, pressure care and continence management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Processes were not always followed to ensure incidents were identified or well managed to protect people.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance process were not comprehensive to ensure people's needs were met or to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Quality assurance processes and oversight did not ensure there were enough staff available to ensure people's needs were consistently met.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Quality assurance processes were not followed to ensure the premises and environment were safe, clean and well maintained which put people at risk.

The enforcement action we took:

This was previously a requirement at the last inspection.