Coate Water Care Company Limited

# Ashbury Lodge Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Ashbury Lodge is a care home (no nursing) for the elderly that can accommodate up to 44 people. The accommodation is arranged over two floors and the home is situated on the outskirts of Swindon. At the time of our visit, 40 people were using the service. The inspection took place on 18 and 19 April 2016. This was an unannounced inspection. The home had been part of the wave one new inspection pilot and a rating was not given in line with our methodology. This was the home's first rated inspection.

There was a registered manager in post when we inspected the service. 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. The registered manager was present and approachable throughout our inspection. Staff, relatives and people who used the service told us the registered manager was always available if they needed to speak with her and had confidence in her abilities to manage the service.

Infection control was not always managed safely or appropriately in the home. This included shared hoist slings with no recording they were being cleaned in-between different people using them. Communal bathrooms and toilets needed attention to make them fit for purpose. We observed a cracked mirror, cracked toilet cistern, a missing ceiling panel and marked floors and general disrepair.

Medicines were not always managed appropriately in the home. This included the recording of medicines, guidance for medicines taken as required and the management of people who needed their medicines covertly.

The home had sufficient levels of staff and they were seen to be visible for people to call on should they need support. The registered manager had a comprehensive recruitment process in place so people were supported by staff that had completed the necessary checks to be able to work with vulnerable adults.

People were given choices at mealtimes and fluids were encouraged throughout the day. However for people needing assistance with their meals this was not always completed in a dignified manner.

Staff had not received all the necessary training to be effective in their role. Only two people in the home had completed training to support people whose behaviour may challenge, yet we saw staff dealing with these situations throughout our inspection. The provider's policy stated staff should have received this training.

Where people had been deprived of their liberty the registered manager had made the appropriate referrals to the governing body. This was implemented after a capacity assessment had been completed and a best interest meeting had taken place. Families were involved in the process.

People and their relatives spoke positively about the care and support they received. They said that if they

had any concerns they could speak to either staff or the management team. They said they felt their concerns would be listened to and where required appropriate action taken.

Care plans were seen to lack detail and guidance for staff to follow. Risk assessments had not always been put in place and monitoring forms were not consistently completed.

Communication and participation in the development of the home was encouraged and feedback was considered and where appropriate acted upon. Relatives were welcomed in the home and involved in their loved one's care.

The registered manager was approachable and available for people to see and worked alongside staff on the floor. People, their relatives and staff felt confident that the home was well managed.

The registered manager had quality monitoring systems in place to assess the service. Things that we identified on inspection had been identified by the registered manager as needing improvement and plans were in place.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

This service was not always safe.

People were not always protected by the prevention and control of infection.

Medicines were not always managed safely or recorded correctly.

People told us they felt safe and were protected by staff who were knowledgeable in recognising signs of potential abuse.

People were supported by sufficient numbers of staff.

### Is the service effective?

**Requires Improvement**

The service was not effective.

Staff had not always received training relevant to their role.

People's human rights were taken into account and respected by the home.

Supervisions had not been completed regularly and the registered manager had addressed this.

Interaction from staff who supported people to eat their meals was not always done in a dignified manner.

### Is the service caring?

**Good**

The service was caring.

People and their relatives spoke positively about the support they or their relative received.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals.

People were encouraged to remain independent for as long as possible and involved in making decisions about their own care.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

The guidance in people's care plans did not always identify how care and support should be provided.

People gave mixed reviews on the activities offered. People commented they would like to spend more time in the outside space afforded by the home.

People and/or their relatives said they were able to speak with the managers if they had any concerns or a complaint. People were confident their concerns would be listened to and the appropriate action taken.

People were encouraged to contribute ideas and provide feedback on the running of the home.

## Is the service well-led?

Good

The service was well-led.

The registered manager was a very visible presence for staff and people. They worked alongside staff on the floor to have insight into the running of the home.

People, their relatives and staff praised the registered manager and felt able to approach her easily.

The provider had effective systems in place to monitor the quality of service to ensure improvements were identified and acted on. We saw things identified on inspection had been picked up by the registered manager through the quality monitoring.

# Ashbury Lodge Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 18 and 19 April 2016 and was unannounced. The inspection team consisted of one inspector, one specialist nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home had been part of the wave one new inspection pilot and a rating was not given in line with our methodology. This was the home's first rated inspection.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We also reviewed the provider information return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with twelve people living at the home and six relatives, fifteen staff members and the registered manager. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for seven people, medicine administration records (MAR), eight staff files, the provider's policies and a selection of the services other records relating to the management of the home.

We observed care and support in the communal lounges and dining areas during the day and spoke with

people in their bedroom. We spent time observing people's experiences at lunch time and observed the administering of medicines. We used the Short Observational Framework for Inspection (SOFI2). SOFI2 is a way of observing care to help us understand the experience of people who could not talk with us. We conducted a SOFI2 on the second day of our inspection in the upstairs lounge.

Requires Improvement

# Is the service safe?

## Our findings

Infection control was not always managed safely or appropriately in the home. We observed on one occasion the cleaning trolley had been left in a person's bedroom unsupervised and people had access to cleaning products that could be harmful to them. Staff were seen on several occasions walking in the corridors still wearing gloves or aprons when leaving a person's room after assisting with personal care. We raised these concerns with the registered manager who was going to address them with the staff.

For people that required the aid of a hoist and a sling to help mobilise we saw that most people but not all had their own slings. We asked staff how the hoist and slings were cleaned in-between use with each person. Staff were unsure about this and unable to provide an answer on if they were being cleaned. They thought the night staff cleaned the wheelchairs weekly but we could find no documented evidence to support this.

We found many of the communal toilets and bathrooms to be in a less than satisfactory condition. For example the downstairs bathroom door felt sticky to touch and around the sink the taps were dirty and the sealant needed attention. An unused continence pad had been left on the radiator. The downstairs shower room had a cracked mirror and the sealant around the floor was black and peeling off. The floor had some black marks on it and part of a ceiling panel was missing. One upstairs toilet had a cracked toilet cistern. A commode toilet had been placed in one bathroom upstairs and was piled high with towels, a cushion and clothing. Another small bathroom was due to be refurbished but at the time of our visit it was still in use. We saw that wet paper towels had been left in the sink, there was a strong odour and the floor was marked and the walls in need of repainting. The bathrooms were not user friendly or pleasant for people trying to freshen up when they needed repair and attention.

This state of disrepair continued into the corridors where we witnessed holes and dents in the walls, black scuff marks along the skirting boards, and areas where the paint was chipped. In one wall there was a large gouge where some of the plaster was missing leaving a hole. The general upkeep of the home needed some attention.

People we spoke with appeared happy with the levels of cleanliness saying "There's a cleaning rota on the back of my door, and there are daily cleans of my bedroom and toilet" and "The cleaners fill in the form on door every day to say it is clean". One relative told us "Mum's room and communal areas are very clean". Another relative said "Put it this way, I never need to bring a duster". However a resident quality questionnaire from December 2015 recorded comments made about the "décor being a bit tired and the bathroom needing DIY". We spoke with the cleaning staff on duty and one staff member reported they had been given no training in hand washing despite been in post for a while.

This was a breach of Regulation 15 (1) (a) (e) Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe living at Ashbury lodge and staff were always available to help them. Comments included "I feel safe having staff here to call when need something", "It's knowing

someone is there if I call", "There's a call buzzer in my room, which can be fixed to my chair or bed wherever it's needed". One relative told us "I couldn't look after her as well myself". Other relatives commented "They keep mum as safe as she can be" and "I make sure I visit at different times, but I've never seen anything I wasn't happy with". We saw that the front door is kept secure by an intercom service so people from outside have to identify themselves before they can enter.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff told us "I would report any abuse, if I couldn't go to the home manager I would go to unit leader, or go to the police, CQC or senior management, I would do that", "Safeguarding means to keep a person safe, if they are at risk you need to raise it, I would go straight to the manager", "We ensure people are safe and secure and in a safe environment and raise any concerns" and "I would be happy to report anything". Only one staff member out of the one's we spoke with was unfamiliar with the term safeguarding.

All staff received a copy of the 'no secrets' policy (guidance on protecting vulnerable adults). The registered manager told us she was an active presence on the floor and would visually check people were being kept safe. The registered manager told us "We encourage staff to report any bad practice, we talk to families and tell them to raise concerns. We are open". For a previous safeguarding concern we saw the registered manager had taken the necessary steps to ensure the safety of people. This included emails sent to people coming into the home to inform them, communicating with people's families, putting signs up in the home, and making staff aware.

People and their relatives shared one concern over protecting personal belongings in their rooms from others that may unintentionally wander into rooms that are not theirs. Comments from people included "Sometimes in the night, residents wander in, which is a bit unnerving, but I ring the buzzer and they are soon taken back to their room", "I would like somewhere to lock some things away in my room" and "I have drawers to keep some things in". Relatives also spoke to us about this saying "I keep mum's expensive jewellery at home because there is nowhere to lock anything away in her room", "[X] glasses sometimes go missing, but are usually found somewhere near" and "The laundry can sometimes end up in funny places. Mum was wearing someone else's skirt the other day". The registered manager explained that anyone could have a key and lock their room and quite a few people did but keys are often lost or people may lack capacity to be able to lock their room. Staff completed regular checks and diverted anyone going into a room that was not theirs. The registered manager said they encouraged people to personalise their rooms and choose pictures for their doors to help identify it as their own. We saw examples of this when we looked around.

Personal evacuation plans for people were clearly displayed in the care office on each floor detailing the level of assistance each person would need in an emergency. We looked at the maintenance manual which detailed items that needed checking daily or weekly, such as building checks, internal temperatures, fire safety and door sensors. This log had been consistently signed to show it had been checked. One staff member told us "We write in the maintenance book, there is a book on each floor and [X] checks it and signs it, they are very good".

People were supported by sufficient levels of staff to meet their needs. We viewed the previous eight week's staff rota's and saw this was consistently the case. The rota's online also showed the length of shift a staff member is working and which floor they had been allocated too. The registered manager told us they never use agency saying "There is a good staff bunch to pick up the shifts if needed, and I will work on the floor, we haven't used agency as there is no need". One relative told us "The staff are always visible when I'm visiting".

Staff comments included "We have enough staff, and have time to chat with people" and "There is enough

staff, we spend time with people". We saw that staff were visible throughout the inspection and available to assist people when needed. The registered manager commented "If there is a need within the home to increase staff I would. I ask the staff if they are happy and I can see from being on the floor how things are working".

We found the recruitment and selection process to be very thorough. The staff files showed that all checks were completed including sourcing two references and a Disclosure and Barring Service checks (DBS). A DBS check helps employers make safer recruitment decisions and prevents unsuitable people working with vulnerable people. The staff files were kept online and information such as certificates of training and identification documents were scanned onto their online file.

The registered manager explained that a few employees were inherited by the previous company and references had not always been in place. For these staff members the registered manager had monitored and assessed them through regular supervision and senior observation on the floor. Everyone employed since 2012 had appropriate references in place. We looked at a new employee's file and saw there was a checklist in place which had been signed to say relevant information about the service had been explained, such as fire exits and polices to read including whistleblowing, health and hygiene and the codes of practice. The registered manager told us when staff are recruited "We do go on the interview answers but also a lot on the personality, as this can't be learned. How they come across and the interaction they have with people is important, we ask people in the home for their feedback".

Medicines were not always managed safely. The home was administering controlled drugs (CD) at the time of our inspection (some prescription medicines are controlled under the Misuse of Drugs legislation and stricter legal controls apply). There was a separate secure controlled drugs cupboard and register to record the medicines. We saw at the top of the drug recording sheet of the CD register it did not have the full details of the strength of the drug recorded. The home's medicines policy stated that 'trained care staff' witness the arrival of CD's from the pharmacy and the same with any returns.

We saw for one person a fax had been sent by the GP in November 2015 stating that medicines could be administered covertly from a 'best interest' decision. There was no record in the person's care plan or on the MAR (medicine administration record that shows the medicines that have been administered to a person) of any discussion with anyone regarding this decision or in which way the medicines should be administered covertly. The staff told us they did not administer the person's medicine covertly.

For people who had been prescribed pain relieving patches, there was not always a body map to indicate the sites it could and should be placed in. We further saw that for people receiving topical medicines such as creams, the MAR's did not always include where or how much to apply.

We saw some medicines for people had been prescribed for use 'as required' (PRN), some of which had been administered on a regular basis. These were being reviewed by the GP. One person prescribed PRN medicine had no guidance in place for staff to follow, stating when it might be appropriate to administer this medicine. We could not find a record that showed this person had ever received this medicine. This was not the case for all the MAR's we viewed. Some had clearly recorded protocols regarding PRN medicines and administration criteria and possible escalation routes if the medicine had not alleviated a person's pain.

Each MAR had been completed with full details of any known allergies. This was also on the front of people's MAR record, underneath their named photograph. One resident had several medicine allergies, which were all clearly recorded.

Only care staff that had been specifically trained in drug administration were responsible for giving people their medicines. People we spoke to felt happy with the way their medicines were managed commenting "The medicine trolley comes every morning with my pills and a drink to take them", "I have lunchtime tablets with a drink" and "The carer puts my tablets on the table for me to take". One relative said "They are good at knowing when she needs more pain relief".

Requires Improvement

# Is the service effective?

## Our findings

New staff were supported to complete an induction programme before working on their own. They told us, "Staff showed me around on my induction and I shadowed for two weeks", "Did training, and shadowed someone, I felt ready" and "Did induction, they showed me the routine, and I had an induction pack to go through with seniors and get signed off". All new staff received an employee handbook and we saw for one new starter an induction checklist was in place covering an introduction to people, the aims of the home, policies, the role of CQC, and information relating to the building.

We viewed staff training records which showed staff were not up to date on all required training. For example 21 staff had either not received training in safeguarding or had not received refresher training in this when it was due. The administrator told us some of these staff members had been booked in for this training in May and June 2016. There were 21 gaps counted for staff who had not received dementia training. The administrator explained these are mostly new staff who will be booked onto a course but there are only places for two staff a month to be sent on the course so it has been hard to get the staff signed off. Some of the staff identified without training were kitchen and housekeeping and the administrator said the priority is to get the carers on the course as they are responsible for supporting people. We saw 35 gaps for staff that had not completed mental capacity training. The administrator again explained this was new carers and a lot of the staff would not be completing this training as it was only for direct care staff.

Staff told us they had not yet completed training to support people whose behaviour may challenge but were assisting people who had these needs. One staff commented "I have had no challenging behaviour training yet". We looked at the training record and saw only two staff had received training to support people whose behaviour may challenge . We spoke to the registered manager who confirmed it was herself and a unit leader who had attended this training, which was an intensive course to be trainers so they could deliver it to staff within the home. The registered manager told us this was in the planning to be rolled out and slides had been created as part of the training. We asked the registered manager how staff were dealing with these situations and were told the registered manager was on the floor to offer advice to staff when these situations arose and the care plans were in place to direct staff.

We observed staff responding well to people during our inspection who at times displayed behaviour that appeared challenging. One staff was trying to support a person to go and change their clothes that had got dirty. This person at first refused, shouting and acted in an anxious manner. The staff agreed a different staff member should try and this method worked with the person agreeing to change and happily going to their room with the staff member. Another person was visibly upset in the lounge area downstairs and we saw a staff member take time to sit with the person and engage them in a conversation about a quiz asking questions and then having a discussion on the answers. Staff told us "We get consent if we can, stay calm, and leave the person to calm down and then go back", "We look at the reasons why someone may be acting this way, get to know our residents so we know the triggers, we give them time or a different staff member attends" and "For one person who is anxious, we use body language to calm people down, and make the environment safe if someone displays challenging behaviour".

One person would shout out repeatedly in distress, and we saw for this person the home had taken steps to support them. The registered manager told us this person had been seen by the mental health team saying "We try to spend time with [X]. The registered manager said she questioned moving this person to a different placement as the home knew this person so well, and this was their home. The registered manager said she had requested one to one support for this person from social services in the hope this would afford the person more time to be supported appropriately, and was awaiting a response.

We reviewed the recently updated physical restraint policy which stated 'The company recognises that it has a responsibility to provide care staff with adequate and appropriate training to deal with challenging behaviour'. The home had not followed their own policy. This meant people were placed at potential risk from staff who had not received the appropriate training to manage behaviour that may challenge.

This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service has a proactive approach to respecting people's human rights and diversity. We looked at the provider's policy on equality and diversity and saw that people's rights were spoken about during the interview process. The registered manager had asked staff to complete a questionnaire which looked at team support and if staff treated one another as individuals and in appropriate ways. The registered manager commented "We are fair when we interview, they have to be able to communicate with the residents. Everyone has rights, the only time we restrict rights is if there is a risk to the person or others".

Staff had previously not received regular supervisions (one to one meeting with their line manager). We looked at three supervision records and saw a gap from July 2015 and January 2016 where no supervisions had taken place. The registered manager told us supervisions were meant to happen six times a year. The registered manager admitted previously it had not been consistent, however some group supervisions had been held but not documented, and the registered manager does a lot of observations on the floor. We saw this had now been addressed and since January 2016 staff had received regular supervisions. The supervision record showed that during these supervisions discussions had taken place around the staff member's job role, the manager's expectations, expectations staff had of the manager, safeguarding and privacy and respect. These had then been signed off by the line manager and the staff.

Staff told us they were now having regular supervisions commenting "Supervisions are useful, done with senior", "Supervisions are regular, and helpful, can raise concerns", "Had supervisions, good for people to say things, and ensure training is up to date" and "Supervisions are regular, not always useful as it's the same thing".

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. We saw evidence of best interests decisions where appropriate and saw they had involved the person's family and social worker. People had mental capacity assessments in place which showed the decisions a person was able to make and which decisions they needed support with. We spoke to staff about their understanding of mental capacity and received mixed answers. Two staff we spoke with were unable to explain what mental capacity was. Other staff commented "Unable to feed self", "If a person doesn't want help, we have to make a best interests decision" and "Lacking capacity is where they can't hold information, can't make decisions. Support people, show people visually, give choices, and work with how they feel". We informed the registered manager of our findings relating to staff knowledge and understanding in this area.

The registered manager had identified a number of people who they believed were being deprived of their

liberty (DoLS). They had made DoLS applications to the supervisory body. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

We saw that six people were already had a DoLS in place and a further thirty four requests had been made. This meant everyone living in the home would be subject to a DoLS if the governing body authorised it. We spoke to the registered manager about the large number of applications and looked at their processes for deciding if someone needed to have a DoLS in place. The registered manager explained the majority of DoLS were made in order to keep people safe because it had been necessary to restrict some of their freedom due to the levels of advanced dementia they had in the home.

The registered manager had a DoLS information folder in place for staff which explained what it means and how to assess if someone was being restricted. The registered manager kept a log of the process which showed when an application had been submitted, received and was awaiting authorisation. We saw the dates were different for each person who had been applied for so the registered manager had completed full assessments of that individual and not acted in a 'blanket type' approach to cover everybody. The folder explained why a DoLS had been submitted, and the decision reached after a best interests meeting had been held. We saw that the registered manager had spoken with people's family before applying for a DoLS. For people that have a DoLS in place it was recorded in the care office on a whiteboard to ensure staff were all aware.

We saw in the electronic care plans some people had a lasting power of attorney (LPA, giving another person the legal authority to make decisions on your behalf if you are unable) in place. It was recorded what decisions the LPA was for. If there was no LPA in place the registered manager had still recorded if family were actively interested in their loved one's care and wanted to be involved in decisions. The registered manager kept copies of people's LPA securely in the office and told us if she has not seen the document for herself, it would not be recorded on a person's file that there is one in place.

We observed the lunchtime experience people had and found there were variations across the two floors. The atmosphere within the downstairs dining room was very interactive and jovial. Seating was in small groups around tables. Upstairs it felt more formal, with people seated at one long table. The registered manager said they had trialled separate tables upstairs but found it did not work and people interacted more with the table this way.

Lunch was served half an hour earlier at 11.30am for those people who needed assistance. The registered manager explained this was so staff had dedicated time to sit with those people. Staff referred to people they assisted with meals as 'feeders', the registered manager told us this has been raised with staff already not to do. We saw one person being given their evening meal at 3.30pm. We spoke to the registered manager about the timing of meals and were told the evening meal is normally at 4pm and then supper is served at 7pm. The registered manager explained people in the home like to go to bed early so they changed the times to ensure people would not miss out on a meal. The registered manager further said there is always food available after supper for people to have anytime. We spoke to the registered manager about documenting that people were happy or had agreed to the timing of their meals being set at these times. The registered manager is going to address this with people.

We saw staff sat with people assisting them with their meal but not much interaction took place during this time. One staff member assisting a person left to answer a call bell. Another staff member left someone to answer the phone and was gone over five minutes. The person's meal was not covered up to keep warm

during this time.

Two people sat in the upstairs lounge waited fifteen minutes without being offered any meal yet two other people in the room were given their pudding. Another person was asleep in front of their meal, and had not eaten much of it. One staff walked by and woke the person reminding them to eat their lunch. This staff member leant over the person, fed them a mouthful, and then walked away. The person closed their eyes again. A different staff member walked by and again stood over the person and put another forkful of food into their mouth before walking on. Eventually one staff member came and sat with this person and attempted to feed them some more despite saying it was now cold. We looked at this persons care plan and saw they required assistance with their meals which had not happened in a dignified manner. The daily record for that day stated this person had been assisted with all meals but we had witnessed this had not happened consistently at lunchtime.

This person was also observed on the second day of our inspection. The person was again very sleepy and had two thirds of the main meal left on their plate. A staff member sat with the person to assist with pudding. We witnessed within a period of three minutes the lunch plate and pudding plate had been removed from this person, and the assistance offered had felt very rushed.

The menus were written on a blackboard in both dining rooms. We saw on the morning of our first day's inspection the menu from three days ago was still on the boards. We spoke to staff about this who told us the activity person is responsible for writing the meal options and they did not work weekends. This meant people had not been able to see what the menu was during this time.

This was a breach of Regulation 10 (1) Dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food and were able to make choices about what they had to eat. Comments from people included "Plenty of choice, nice home cooked food. Piping hot, I always finish it all", "I asked for cheese and biscuits last night and they made no fuss at all", "I can ask for a snack at any time. I had some toast mid morning" and "There are drinks in my room and living area and dining area, so I never go without".

People had access to plenty of fluids and we saw people being served mid-morning and afternoon hot drinks and snacks, and regularly being encouraged to drink by staff. At mealtimes staff plated up the two meal options and took the plates to people to choose from so they could see and smell the food to assist in their choice. One relative told us "Although [X] really can't make choices verbally, they will show her both choices of hot lunch for example and she'll point to which she fancies". We saw staff offering people the choice to wash their hands with a hand wipe before their meal if they wished.

The head chef had recently attended a training course for soft diets and spoke about the different levels of textures and presentation for people on this diet. The head chef said they have the opportunity to speak with people about the food and when new things are put on the menu, the chef asks staff to get feedback from people.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. Staff told us a regular GP visits the home every week and the staff write people's names in the book who needs to or would like to see the GP. People told us "The GP comes to visit every week", "The carer took me to the hospital to see if my hearing aids were working", "A carer took me to hospital as I had pneumonia. I had to stay in for a while, but I was glad to go home" and "I get taken to get my feet seen to". Relatives felt reassured that their relatives were monitored and supported

to access medical care when required saying "The GP visits regularly if we have any worries", "I don't think she's been ill since she's been here" and "A GP comes in weekly and the staff will take [X] for other appointments".

We saw a list was kept in the privacy of the care office which stated which people had a DNAR (do not attempt resuscitation) in place so staff had clear access to that information. We saw that one person's DNAR had not been discussed with the family by the GP, as they were absent at the time it was put in place and had been recorded as pending. We saw another DNAR also had no recording of a discussion with the person's family. This had been picked up by the registered manager and the family had been informed and discussions around this had been held and documented in the person's care plan. The registered manager is going to further address this with the GP.

The home was nice and light and people had access to a large conservatory room called the summerhouse. People enjoyed utilising this space to sit quietly, spend time with relatives or participate in an activity. We saw a noticeboard in the entrance which displayed useful information for people including a brochure on living with dementia, mental capacity and deprivation of liberty. Fresh flowers welcomed people visiting the home and a photo staff board showed the staff members in the home and their roles and names. An allergy and intolerance board was displayed asking people and their family to let staff know if anyone has any dietary concerns. The rotating four week menu was also on display showing all the options available. People told us "I like it here, it's home now" and "My room is lovely, I have all my things here with me".

The home predominantly had people living in it who had received a diagnosis of dementia. During the visit we did not see much available that portrayed the home as specifically dementia friendly. The walls were all the same white colour and there was the odd picture or painting along the corridors. We spoke with the registered manager about this who told us the home has had support from the dementia care team at the local hospital and the registered manager herself is also dementia trained. The registered manager commented "I look at individuals and what they enjoy, I have trialled putting things up, and I am going to discuss with maintenance staff about having a themed corridor and changing the colour of the toilet seats". The registered manager told us one person had a sensory blanket in place, and the home is encouraging the life story work, to build up a picture of people's history. The registered manager said she has done research work and sourced pictures for those people that can't be provided by family to support their memories.

Good

# Is the service caring?

## Our findings

People were treated with kindness and compassion in their day-to-day care by staff who had got to know them well. People told us "All the staff are lovely & caring", "They very often think of things I've forgotten about. Like my glasses I'm always putting down", "I love it here. I have all my friends here with me", "They are very friendly" and "They all know me, but I can't remember all their names". One relative told us "They treat her just as I would". Another relative said "Mum is always clean, tidy & well presented".

People's care was not rushed enabling staff to spend quality time with them. We saw throughout our inspection staff were afforded time to sit and chat with people. One person told us "They sit down with us all the while". Another person commented "I love sitting with the staff and chatting to them". Relatives also commented on time spent with loved ones saying "They are very caring, taking time to talk to her normally" and "They take their time to care properly for her and she's not easy these days".

Staff displayed a caring attitude towards people, from sitting down to ask a person about their day, to offering to fetch a person a cardigan because they looked cold. We saw the maintenance staff stopping to have a chat and laugh with people and assisting them along the corridor if they needed help. Staff comments included "The residents are the main thing", "I love working here, it's like visiting my grandparents", "We keep it homely, give choices, and respect that we work in their home" and "If you can make someone smile or laugh your day has been worthwhile". We saw that on coming to live in the home people were presented with a welcome pack containing useful information about the service and what to expect to help people settle in.

Staff knew people's individual communication skills, abilities and preferences. One staff member told us "If people can't communicate things, we find out from their family or we write it down if they have no verbal communication". Relatives praised staff commenting "My mum needs things explaining more than once and they are very patient with her", "They talk to [X] as a normal person. I value that", "They cope with [X] better than I do" and "My Mum's been a resident for two years, they know her better than anyone else". We saw 'this is me posters' had been put in people's rooms which contained a snapshot of that individual detailing some likes or dislikes and a brief history. This enabled staff to have a glimpse of the person and learn about people each day starting conversations from the knowledge shared.

People's privacy was respected by staff. Staff explained they ensured doors and curtains were closed when supporting with personal care. One staff said when the district nurse visits if the person is sitting in a communal area and doesn't want to go to their room, they have a screen they will put around to offer privacy during the visit. One person said "They explain what they've come to do for me". Staff communicated well with each other updating one another on who they had supported and where they were going next.

Staff told us that people were encouraged to be as independent as possible and make their own choices. Staff commented "I encourage one person to lay the table with me, another person does the napkins, it keeps their mind occupied" and "I show people their clothes, I write things down to help them choose".

People confirmed they were involved in decisions saying "I'm fussy, I like things a certain way, but they are very good and accommodating", "I decide what I want to wear each day", "I like an early morning, I get a knock at 6am, but I like to go to bed early too" and "I can get myself up anytime I like". Relatives also spoke about their relatives independence saying "Her clothes are shown to her so she can choose what to wear", "[X] does as much as she can" and "To be honest, she's just happy sitting in her chair, but they will encourage her to do as much as she can for herself".

The registered manager told us the home speaks with people and their families about any wishes or preferences a person may want upheld when approaching end of life care. The registered manager explained this is often hard to ascertain as many people have not had those conversations with their family and the level of their capacity is such they are unable to express it themselves now. The registered manager said the home does need to improve upon the end of life documentation and a life history is always sent to the person and family prior to coming to live at the home to ensure it is completed and not forgotten about. The registered manager said the home receives good support from the prospect nurses (hospice service providing support for end of life) when a person they are caring for starts to deteriorate.

Requires Improvement

# Is the service responsive?

## Our findings

Care plans were kept online and secured with individual passwords and login details for staff. Depending on the level of the staff member, for example if they were the registered manager, senior or care staff they had different levels of access of what information was available for them to see. Each file had a picture of the person and showed when a review of their care plan was due. One relative told us "We have regular meetings to discuss mum's care". Another relative said "I always get invited to talk about [X] care usually ever year or so, but I can request a meeting at any time". We saw that care plans relating to the use of mobility and lifting aids were individual and very clear in detailing their requirements.

However care plans were seen to lack detail and guidance for staff in supporting people's needs. For example one person was recorded as being withdrawn and depressed but there was no further information on how this was managed and what support was being offered to this person. It also stated this person could on occasion become abusive but there was no guidance in place for staff on what actions to take. The person's behaviour had been given a score but there was no detail on what this score meant for supporting this person. No risk plan for this behaviour was in place, and during our inspection we observed this person appearing challenging towards some of the other people living in the home. Another person was recorded as being a danger to their self and others, yet again there was no risk plan in place for this behaviour. A further person's mental health care plan documented that they could be 'varied in their moods' but no further detail of what this looked like or what staff should do in managing this.

One person had their personal care needs recorded as 'needing assistance from one carer' but no detail was provided on what the level of assistance was that this person needed and what the person may be able to do for themselves. We saw a lot of generic statements such as offer reassurance and maintain dignity but nothing that was person centred to each individual. The registered manager told us a meeting was going to be held with senior staff concerning the re-wording of care plans, as this had been recognised it needed re-doing. Another person was recorded as having had an un-witnessed fall. The accident form had been ticked as complete but nothing had been filled in regarding the management actions or any future preventative measures put in place.

One risk assessment had been put in place for a person who smoked. The person was unable to smoke alone due to safety reasons so staff would accompany the person outside. The assessment did not state how often it had been agreed with the person that they would have a cigarette. This meant staff were dictating the times when this person would be able to smoke. We saw this person asking staff throughout our inspection if it was time for a cigarette and on some occasions staff would tell the person no, as they were busy. We raised this concern with the registered manager and by the second day of our inspection the care plan had been amended to reflect agreed times staff would accompany this person to have their cigarette.

We saw in one person's care plan they had scored as being 'low risk' of nutrition concerns but another assessment contradicted this recording a recent weight loss of more than 3.5kg and stated the person only eats half of their meals. The person had been weighed regularly. Another person had been prescribed an

additional nutritional drink by the GP which was recorded on the MAR and showed the person was receiving it. However the only record of this in the care plan was documented in the person's likes and dislikes but not within their nutritional care plan. We raised this with the registered manager who is going to address it.

Senior carers were responsible for reviewing people's care needs and risk assessments to ensure information recorded was up to date. However we saw that on occasions when a concern had been identified action was not always taken. One person had been identified as being at risk of drinking insufficient fluids so a specific action plan had been devised requiring them to be encouraged to take 1446mls in 24 hours. The person was recorded as having a consistent intake of 550 to 600 mls every 24 hours which fell below 50% of the recommended amount documented as to be encouraged. We saw the review reported 'no change required'. We saw however throughout the inspection people did have access to drinks and were regularly offered fluids. This sample was not representative across all people living in the home.

The home had a creams folder upstairs for people needing support in applying prescribed creams. The folder contained information on where to apply the cream but we saw large gaps in the recording with no codes to explain why there was a gap. One person was having cream applied twice a day, we saw it had been recorded they had received it once in one week and not at all the following week and then only once since the 2 April 2016. Another person was having a skin protector gel and cleanser applied after every continence pad change. There was nothing recorded for a period of seven days and on other days there was only one signature.

We looked also at the MAR's for creams downstairs and found these were also not consistently signed. We saw in the documented supervision minutes that the registered manager has recognised this as a problem and previously raised this concern with staff members charts so it had been addressed.

The home had a bath chart in place, which had recorded people's names next to a specific day of the week. We asked staff what this meant and were told each person is allocated to a day to have their bath; if a person refused on their allocated day they would be offered it again the next day. We raised this practice with the registered manager who said this was not what happened in practice, and that anyone could have a bath or shower any day of their choosing. The registered manager said the chart is going to be addressed.

Turning charts had been completed appropriately detailing how often a person needed assistance in changing position, and recorded the position the person had last been in and what they had changed to. There was a column for staff to report on the person's skin condition if it was intact, or broken but we saw staff were using this to record if a person had been to the toilet or had received a continence pad check.

One person had been referred to by a different name throughout their care plan than what was recorded as their name. There was nothing in the preferred name box to say this person wanted to be called any other name. We asked staff and were told it was the same person and it had been an oversight not to record this. The registered manager told us the home needs to work on the care plans and the documenting and evidencing.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered a variety of activities they could be involved in. We saw activity boards were clearly displayed with pictorial signs of the planned week's activities. Activities on offer included arts and crafts, a film afternoon, bingo and a garden centre trip. The home had a hair salon and we saw people having their hair done during our inspection. Two activity staff were employed to coordinate the programme of activities

available to people and we saw them engage people in group and individual activities.

People and their relatives gave mixed reviews on the activities provided. People told us "We go to Coate Water and went to the theatre last week", "I wish we could go out more often", "There are activities, but they are very childish, so I don't usually join in", "My friend and I are usually the last one's up playing cards. I will miss it when I leave shortly", "I walked in the garden with my sticks yesterday in the nice weather, but I have to wait to be let out" and "It gets boring here especially at weekends and in the evenings. We play cards a lot". We spoke with people's relatives about opportunities for people and comments included "Activities only really take place in the afternoon, Monday to Friday which makes for long evenings and longer weekends", "It would be nice if there were more outings. They go to Coate Water and local garden centres, but a few more outings would be great", "The activities aren't always suitable for everyone, so they get left out" and "A few more activities, particularly weekends would help as its long days for the residents".

We spoke to staff about the level and type of activities provided for people and were told "I would like to see them go out more, they can't go in the garden without supervision", "There's enough for people to do", "It's hard to stay focused on things, upstairs don't go down to the summer house enough, they need staff to assist them to go out more" and "There is enough to do, the bingo has prizes and they love it. We have an Easter raffle and summer fete". We observed an afternoon activity in the Summerhouse. The activity staff asked most people to join in but only three people chose to and they spent time making decorations in light of the Queen's upcoming birthday. Whilst engaged in the activity, there was a lively, interactive discussion about St George's Day, Shakespeare's birthday, and the Queen's 90th. Other people had chosen to have a sleep or read quietly.

We spoke with the registered manager about people not being able to access the garden without supervision. The registered manager explained that this has to be the case for some people in the home due to the levels of their advanced dementia they need support to keep safe when outside of the home. The garden was secure but was laid with patio not grass and the registered manager said they prefer a staff member to be around when people are outside. We saw that the door to the garden was left open at times so people downstairs could access it and if people wanted to go outside a staff member unlocked the door for them.

We conducted a Short Observational Framework for Inspection (SOFI2) in the upstairs lounge during the afternoon. This allows us to observe care and interactions to help us understand the experience of people who could not talk with us. We did this primarily to understand the levels of engagement people received from staff. The SOFI2 showed us that everyone we observed received some form of interaction during the half an hour observation. We saw one person appeared anxious and upset and staff took the time to sit and reassure that person. Staff checked on everyone regularly and initiated conversation and engaged people in playing a game if they chose too.

Relatives were welcomed into the home and encouraged to maintain links with their loved ones. People commented "I think my daughter comes most days", "My daughter always seems to be here" and "My family visit and take me out". Relatives told us there were no restrictions on when they could visit saying "I'm always felt to be very welcome", "From the first time we looked around, I've felt very welcomed", "I come and go as I like, I've never been stopped from visiting" and "I'm always rung up if mum falls ill or something has happened".

People had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. One person told us "I'd talk to the Manager if I had concerns". Relatives were also comfortable to raise concerns saying "I can talk to anyone at any time", "I've never not got an answer

when I've needed one" and "The manger would be my first contact". We reviewed the complaints log and saw where a concern had been raised an acknowledgement letter had been sent, then a further letter stating what had been done in response, and a further meeting offered. At the time of our inspection there was not easy read complaint information available for people. We raised this with the registered manager who is going to address this.

The registered manager said it had been raised by families that staff were not always available to offer and make relatives and visitors a drink when they came to the home. The registered manager had explained that although staff will always be mindful to welcome people and offer refreshments, their first priority is to look after the residents. The registered manager said the issue was taken on board and a drink station was created in the entrance hall for relatives and visitors to help themselves to a drink if staff were busy assisting people. The registered manager told us this had worked really well and had a positive outcome.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Resident and relative meetings were held every three to four months and the registered manager said the home "offers cake and coffee to entice people to come". Signs are put up around the home to remind people and emails are sent to family members. We saw the minutes of the last meeting held in January 2016 had been put on the noticeboard so everyone could read them if they had not been able to attend. Items that had been discussed included asking family members if they wanted to volunteer within the home, CQC inspections, complaints process and staff. Items that had been raised by people or their relatives had been responded to by the registered manager and actioned where possible. We looked at the folder of compliments that had been received and saw cards from people and their families thanking the home and staff for the support, care and kindness shown.

Good

# Is the service well-led?

## Our findings

The registered manager was a positive role model to staff and promoted a positive culture that was open and inclusive. The registered manager was a very visible presence on the floors and assisted people and staff where they needed help including with personal care. People and staff that we spoke with confirmed that this was the 'norm' from their registered manager. One person told us "She wanders around all the time". Another said "She likes to sit and chat with me". Staff also commented saying "The manager is up and down on the floors", "We have support from the manager, she is approachable", "She is very approachable, she has an open door, and is available, even rings on her days off" and "It's run nicely, if there are any problems I can go to the manager".

We saw on our second day of inspection the registered manager had spent time in the morning supporting people to get up. The registered manager explained that the previous night a person had fallen and gone to hospital returning this morning. Staff had spent time supporting this person so things had run behind so the registered manager had worked on the floor. The registered manager said "I helped out on the floor to get back on track, we all muck in together because we are a team". The registered manager further told us "I have to know what's going on with all the residents. If I don't work on the floor I don't know what's going on".

Relatives told us they found the registered manager very approachable commenting "The manager is very welcoming and I can talk to her anytime" and "No problem finding [X] if I need her". The people we spoke with were all aware who the registered manager was and told us they see her and chat to her every day she works. The registered manager told us "It's a homely place with a happy vibe; if we need something we will get it". The care offices situated on each floor were in the dining and lounge areas and had glass windows so people could see if staff were available should they need to chat.

Staff were supported to progress within the home, with many completing their level 2 in health and social care. Some competent staff have also had the opportunity to progress to senior level within the home. The registered manager explained the importance of supporting staff commenting "If staff aren't supported, things can lapse, I have an open door policy". We saw staff were able to attend regular staff meetings and minutes from these minutes showed staff were made aware of events happening in the home and had the opportunity to raise things if they needed.

There was no identified room for staff to take their breaks in. Staff said they were permitted to use the summerhouse if people were not using it otherwise there was a few seats by the lockers which was accessible by people living in the home and a landing space on a stairwell had some chairs squeezed in to it. This space did not afford staff a quiet space to make a drink or relax in-between work. We spoke to the registered manager about this who explained the home did not have that much extra space but is going to look into the situation for staff.

The registered manager valued people's feedback and acted on their suggestions. We saw a quality questionnaire had been given to people living in the home in December 2015. From this survey the

registered manager had made an action plan to address individual specific issues and meetings and discussions with individuals had taken place. People had raised they would like fruit bowls to be available around the home and the registered manager had actioned this and we saw fruit bowls around during our inspection. A relatives quality questionnaire sent twice a year had picked up that people were not sure about the complaints process so the registered manager sent everyone a copy. The registered manager told us "We want to improve and we want to learn. We share good practice". The registered manager had been due to go to another home that had recently been rated as outstanding, to have a look around and inform practice within Ashbury Lodge. This was prior to our inspection but the registered manager said it was still a learning opportunity and would still go.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Although we had picked up things during our inspection these were shortfalls that the registered manager had herself identified from her audits and was putting plans in place to address. We saw monthly kitchen audits were completed by the registered manager. Where things had been identified the manager had set actions for the kitchen, re-audited and recorded that it had improved.

We saw that the registered manager's audits had picked up staff were not having regular supervisions and this had been addressed and was now happening regularly for staff. Staff are allocated to a number of people and complete checks on their bedrooms for maintenance and to see if anything is needed such as clothes or toiletries.

People's weights and risk of malnutrition were monitored by the registered manager who used the Malnutrition Universal Screening Tool (MUST). This risk assessment was reviewed monthly and also considered over a three monthly period to identify any changes. An action plan was developed if there were concerns, and the kitchen informed so menu plans could be taken into consideration. If required, a discussion would be held with the GP and referral to a dietician would be made. The registered manager printed off people's waterlow score (waterlow gives an estimated risk for developing a pressure sore) and monitored this to consider what pressure care equipment may need to be implemented. We saw that the person we had identified as having lost weight was included on the registered manager's audit to be monitored.

The Infection control audit completed in April 2016 gave a score of 80.6%. The registered manager told us she has requested for the service's operations manager to come out and discuss a few things raised from the audit. We saw in the diary a date had been set to discuss this. A health and safety audit completed in April 2016 had again raised items that the manager had arranged to speak with the operations manager about. This included some but not all of the things we had identified during our inspection.

The registered manager had recently identified that accident reports from the care plans were not being reviewed. The registered manager now pulled this report off monthly and reviewed it, taking any necessary actions and looking at possible trends.

Each month a report is sent to head office. We saw this included information about the home's occupancy, any CQC visits, medicines, audits, any deaths or new admissions, complaints and falls. The registered manager told us the operations manager comes and visits the home and the owners were coming the day after our inspection to award staff with long service awards and thank them for their commitment to the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People were not always supported with their meals in a dignified manner. Regulation 10 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The communal bathrooms were in a state of disrepair. Staff were seen wearing gloves and aprons in the corridors after supporting with personal care. The cleaning trolley had been left unattended in a person's bedroom. Regulation 15 (1) (a) (e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Care plans were seen to lack detail and guidance for staff in supporting people's needs. People's prescribed cream charts were not completed appropriately. Action was not always taken from risk assessments. Regulation 17 (2) (c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not all up to date on the necessary training required to perform their role. Only two people were trained in challenging behaviour |

despite the staff supporting people who displayed challenging behaviour. Regulation 18 (2) (a).