Health & Care Services (UK) Limited

Ashfield Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 January 2017 and was unannounced.

The home is in a purpose built building all on one level. The home is registered to provide accommodation with nursing care for a maximum of 20 older people or people living with dementia. There were 15 people living at the home when we inspected all of whom required nursing care. There was also a day care centre attached to the home but this was staffed separately.

There was a registered manager for the home. 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.

However, on the day we inspected the registered manager was not available. The operations manager told us that the registered manager would not be returning to work as they had not effectively managed the home. Following our inspection the registered manager contacted us and told us that they had appointed a new manager and deputy manager for the home.

The provider was not meeting the legal requirements in multiple areas of the home. They had failed to take action to ensure that people's rights were fully protected under the Mental Capacity Act (2005). They had failed to ensure there were enough staff available to meet people's needs in a timely way and that the staff received appropriate training and support to help them develop the skills needed to provide safe care. We found that care was not always planned to reduce the risks people faced and that the guidance for the administration of medicines prescribed to be taken as required was not always adequate to ensure consistent care was offered. People did not receive the support they required to ensure they received enough to eat and drink. The care provided did not meet people's individual needs or ensure that they were calm and settled and able to live full lives.

The provider had failed to improve the quality of care since our last inspection and to effectively monitor the quality of care people received. They had not taken successful action when concerns were raised about the registered manager's abilities to stop people experiencing a decline in the standard of care they received. You can see what action we have told the provider to take at the back of the full version of this report.

Staff knew how to keep people safe from abuse and knew how to raise concerns both within the organisation and with external agencies. Appropriate checks had been completed to ensure staff were safe to work with people living at the home. However, the use of agency staff meant that people did not receive care from people they knew and trusted.

Staff provided care that was task focused and at did not always put people at the centre of the care provided. Where people had communication difficulties they were not always offered choices of asked for

their opinion on the care they received. People were not always supported to manage their appearance in the way they had done before moving into the home. Activities were not fully utilised to keep people calm and settled and to lead a fulfilled life.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff to meet people's needs in a timely fashion.

Some risks to people had been identified; however, care did not always fully protect people from the risks.

The systems in place did not support consistent administration with medicines prescribed as required.

Staff knew how to keep people safe from abuse and how to report any concerns.

Recent improvements meant that people were protected from the risks of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not fully supported to develop the skills needed to provide safe care. Staff did not receive consistent supervision to help them develop their care skills.

The provider had not ensured that people's rights were fully protected under the Mental Capacity Act (2005).

People were not supported to access enough food and fluids during the day.

People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always provide caring support.

People who were able to communicate with staff were offered

choices about their care. However, care staff did not support other people to make choices.

People were not always supported to keep up the level of personal appearance they maintained before they moved into the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The care provided did not support people to be calm and settled.

Activities were not used to distract people from distressed reactions.

People knew how to raise complaints but felt that these were not used to improve the quality of care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had not taken action to improve the quality of care provided following our last inspection and had not taken action to prevent further deterioration in care.

Systems in place to monitor the quality of care had not been used effectively.

People living at the home had not had their views sought on the quality of care provided.

Ashfield Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 care, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 30 January 2017 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who lives in this type of care home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke with five people who lived at the home and three visiting family members. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with a two care workers, a nurse, an agency nurse, the domestic staff and the operations manager.

We looked at four care plans and other records which recorded the care people received. In addition we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People had monthly dependency assessments completed to identify the level of support they needed. However, these were not used to inform staffing levels. The operations manager explained how staffing levels were set at the same level across similar homes within the company. Records showed that staffing levels had been maintained at the levels identify by the provider.

However, we found that people were not supported to receive care in a timely fashion or monitored effectivity. People living at the home and their relatives raised concerns with us about the staffing levels. One family member told us, "They always say they're short staffed to me. We've had long waits when we call them to move him. I found him the other day slumped down sideways on the bed and he couldn't breathe properly." Another family member told us, "I've been in the lounge before and had to stop people from falling. No lounge supervision." At 11.40 am one member of staff identified that they still had two people who had not received their morning personal care.

At 3.30 pm we saw the lounge area was unsupervised, one person who was sitting in a wheelchair had attempted to get up and was nearly in the floor. The maintenance man stood in the doorway and did not raise an alarm. We asked staff to help the person be safe. This person was at risk of falling and had a lap belt in place to help them stay safe. However, we saw that they could and did frequently undo this. This meant that the person required a high level of supervision to keep them safe.

Staff told us that they did not feel the staffing levels were appropriate to provide safe care for people. One member of staff told us, "Well, they're trying to manage with just three on a shift but an extra would make all the difference, as these guys (people living at the home) suffer otherwise. Today we've been chasing our tails as night staff hadn't done anything. If activities [staff] aren't here, we'll try and get 15 minutes with them in the afternoon if we can. But it all depends."

The home did not have enough directly employed staff and relied on the use of agency staff. We discussed with the nurse agency staff were supported to manage the care safely. They explained that the nurse who handed over to the agency nurse would complete a through handover and ensure that the agency nurse had contact details for the doctors and other people to contact in an emergency.

There was only one member of domestic staff employed. They had been working on their own for six months. Despite the registered manager being aware of the situation they had not increase the domestic staff. They told us at times they had worked sixteen days without a break. In addition to the cleaning they were also responsible for managing the laundry.

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

People living at the home told us that they normally felt safe. However, relatives did raise some concerns regarding the safety of the care their family members received. One relative told us, "She's safe, but I've

pulled them [staff] up before about sitting her up square in her wheelchair so she doesn't bash her head on the door." This family member commented how they had brought a special chair which helped people maintain their posture and provided pressure relief. However, they said the staff were reluctant to use it. Another relative said, "[Name] has had pressure sores since they have been here, on his spine, bottom and legs. They say he scratches himself but I don't see how he can reach. He's got dressings all over."

Records showed that most risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers and equipment was in place to reduce the risk of occurrence. However, we saw and information in the staff meeting minutes confirmed that the paperwork recording the monitoring and care needed around pressure care was not fully recorded.

In addition, the information did not always support staff to manage the risks. An example of this was one person who was tall and had their bed lengthened to give them some more room. However, the pressure mattress was a standard size and therefore was not suitable to provide the level of protection needed. Furthermore, their care plan recorded that their pressure relieving mattress should be set to provide protection for their weight, but the person had lost a significant amount of weight recently and the care plan had not been updated. We discuss this with the nurse who immediately reviewed the pressure mattress settings.

Where people were at risk of falling and they did not have the capacity to understand the risks they had pressure mats in place to alert staff when they got up. This enabled staff to provide immediate support. In addition regular checks were in place during the night to ensure people remained safe. However, family members told us that they were not always assured that the appropriate levels of support were available. One family member said, "[Name] has had a couple of bruises from unseen accidents. But [name] walks and paces a lot as [name] is very mobile."

Care plans did not include enough information to ensure that people received their medicines as prescribed. People told us that while staff administered their medicine safely they had not always ensured that they had been administered in a timely fashion. One relative told us, "The Parkinson's nurse saw him recently and said his lunch medication was too close to his morning one and made staff aware to space them out more." Another relative said, "She's on minimal medication so I'm happy. She's got no sores either. But she has dry skin now and they got aqueous cream from the doctor and it's still unopened after three weeks."

We observe the medication round which was completed by the agency nurse. There were photographs in place to aid correct identification of people. We saw the agency nurse check the medicine with the medicine administration record (MAR) to ensure they administered the correct medication to the correct person. However, some of the MARS had extra instructions written on them which contradicted the medicine's label which noted how many tablets the person should take through the day. This meant that information about the administration of medicines was not always clear.

Some medicines were prescribed for people to be taken as required. For some of these medicines there was no guidance available in their care plan or MAR about when the medicine should be offered. We asked the agency nurse when one medicine prescribed to be taken as required would be administered. They were unable to tell us as they did not know what the medicine was for and there was no guidance available. In addition, where protocols were in place for medicine prescribed to be taken as required they did not contain enough information to support staff to administer the medicines consistently.

During our inspection a person was admitted to the home, we saw they brought their medicine with them and this was checked in with the agency nurse. It was the provider's policy and good practice that medicines needed to be checked two members of staff to reduce the risk of errors. However, there was no member of staff available to double check the medicine with the agency nurse. This meant medicines for this person would be unable to be administered until night staff had completed the check.

Audits showed that the deputy manager who was also a registered nurse had not completed the required training from the nominated training provider for the safe administration of medicines and the online course had not been allocated to them on the computer training programme.

These shortfalls in managing risks to people and medicines were breaches of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Record showed some people were given their medicines with food so that it was easy for them to swallow. Where people had been unable to make this decision it had been discussed with their family and the doctor and a decision was made in the person's best interest about how to safely administer the medicine.

We noticed some odorous areas within the home and this concern was also voiced by a family member. Over the Christmas period the home had had a prolonged outbreak of a stomach virus. This had lasted three weeks. It was reported to the appropriate authorities and support was gained from public health professionals to try to end the infection. The operations manager explained how concerns had been raised by the local authority that appropriate action had not been taken to manage the risk of cross infection. They explained that once this issue had been identified staff from another home had visited to clean and contract staff had been appointed for a three day deep clean the home. There was now an infection control action plan in place and the nurses had been working with the local authority infection control team to reduce risks.

Domestic staff told us how they worked to reduce the risk of infection. They told us they had completed their infection control training online. However, they told us that they had been unable to keep up standards as they had not had appropriate equipment or staff. The operations manager told us they had purchased the equipment needed to continue to maintain the home at an acceptable level of cleanliness. They were also in the process of employing another housekeeper to help maintain standards.

Infection control processes were not always followed by the care staff. We saw one member of staff who had a cold sneezed, they did not have a tissue and used to their top to catch the sneezes. This increased the risk of cross infection and we noted that a number of people in the home currently had colds and chest infections. In addition concerns were raised over the care staffs lack of consistent use of appropriate protective equipment when supporting people to the toilet.

Staff told us they had completed safeguarding training online. They were able to tell us about the different types of abuse and how they may be able to identify people who were at risk of abuse. Staff were confident about raising any concerns they had with the registered manager. However, some staff told us they were not sure how they could raise issues directly with external agencies. Records showed that since our last inspection the provider had appropriately raised an issue with the safeguarding authority and had taken appropriate action to keep people safe.

The provider had a whistle blowing policy. Whistle blowing is where staff are able to raise concerns anonymously if they wished and are protected by law from any retaliatory disciplinary action. The operations manager told us that they had received a number of concerns from staff about the home through

the whistle blowing telephone number. The provider was in the process of investigating these concerns.

People had emergency evacuation plans available in their care plans. This recorded the support they would need to move to safety in an emergency. It also recorded their level of confusion and how they may act to assist staff from the emergency services to provide safe care.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who lived at the home.

Requires Improvement

Is the service effective?

Our findings

The provider had not supported the staff to develop the skills needed to care for people safely. People told us that some of the staff needed further training and support to be able to care for people safely. One person told us, "I think most are good but some don't take their time and can be a bit rough." A family member said, "Some need more training and knowledge. It's the level of care that concerns me."

New staff told us they were meant to complete an induction programme when they started working at the home. This included time spent shadowing experienced staff, having their skills checked by a senior member of staff and completing the care certificate. The care certificate is nationally defined training which should provide staff with the skills needed to care. However, one member of staff, who had worked at the home for over a year, told us that their induction had not been completed and that they had not completed the care certificate. This person had not previously worked in care and therefore the provider had no assurance that they had gained enough skills to deliver care safely.

Staff told us that the training was based around learning packages on the computer and that they rarely received any face to face training. Staff said that they would prefer more face to face training as a computer could not answer their questions or provide feedback on their skills and areas for improvement. Staff also told us how the training system had changed and that they now struggled to access it. In addition, were not able to do the training at work as there was no computer available which could access the new training system.

Staff also told us that they would like more training in key areas such as how to manage people when they became distressed as they felt this was a concern in the home. An example of this was one person in the home who was difficult to get to accept personal care. Staff told us that at times three members of staff were needed to provide personal care for this person. They explained that however gentle they tried to be the person found it traumatic.

In addition the nurses told us how they were not supported to continue their professional development and stay up to date with the required skills and knowledge. While they completed self-directed learning this was not supported by the provider and not related back to appraisals or staff's identify training needs. The provider had not supported them with training in key areas such as diabetes and palliative care.

The nurse told us that supervisions should be completed on a three monthly basis. However, staff told us that they had not received their supervisions on a regular basis. One member of staff told us that there was a lack of options for career development. Staff told us they had not received an appraisal on a yearly basis.

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

There were systems in place to ensure that agency staff were given enough information to enable them to work safely. This included a brief induction the first time they worked at the home and information relating

to fire procedures and medicines. The agency nurse told us they felt they had enough information to be able to care for people safely and that they had been given an appropriate handover when they started a shift at the home.

The provider had not always ensured that people's rights were protected under the Mental Capacity Act 2005 (MCA). The 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 told us that staff did not always ask for consent before assisting residents with care. One family member told us, "They rarely ask her first and she can answer if they take the time to let her." However, when people had been assessed as not being able to make a decision the MCA had been followed and decisions had been made in people's best interest. Staff had ensured that family members and appropriate healthcare professionals had been involved in making the decisions.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were 12 people living at the home who were unable to make decisions about where they lived and needed to be assessed for DoLS authorisation. For five of these people their deprivation of liberty had expired. There was no evidence the appropriate reapplications had been submitted. The nurse told us that things had slipped due to having so many agency staff as it had created a lack of continuity and they were unsure of what action had been taken to protect people's rights.

This was a breach of regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had a condition on their DoLS about having a daily walk. They were regularly offered walks, however, as it was winter and cold outside they would often get to the door and refused to go out.

People were not always supported to access food and drink. Family members were concerned about people being offered enough food and drink. Some families told us they found their relative thirsty on arrival and had raised concerns over the lack of assistance to drink given by staff. We found no jug of water or squash provided in people's bedrooms. No cold drink was available or served through the day in the communal areas, although squash was served with meals. One family member told us, "I ask them to make sure he gets plenty as he has to be assisted and has thickener too. He was thirsty this morning, I gave him a whole cup in one go, and it's not the first time he's been desperate." A member of a different family told us, "She doesn't get as much as I'd like – she'll drink three or four cups when we're here and is always thirsty. She likes a drink of tea or cranberry squash but needs help."

Most people happy with the food. One family member said, "He's a good eater and they often give him seconds. He'd lost a lot of weight at the previous home but it's come up being here and has stabilised." A person living at the home said, "I enjoy my meals and I'll eat in my room or the dining room. We get a choice and I'm easily pleased with what we get." People were offered a choice of meals and the chef was happy to accommodate any requests that people had. For example, one member of staff told us that a person would

often request pancakes as they enjoyed them.

However, staff told us that budget cuts had impacted on the food and drinks available for people. For example, they told us that biscuits had not been offered with the afternoon tea as there were no biscuits in the home, there were no crisps available and that there was often no fruit juice in the home. Having access to snacks is important for people living with dementia as they may often decline to eat a meal but will eat snacks while walking around. In addition, one person who was struggling to maintain their weight would often drink fruit juice when they refused other things so was at an increased risk of being unable to maintain a healthy weight.

Where people needed support to eat this was not always offered safely and consistently. An example of this was a person who was sat in the quiet lounge with their breakfast. they were alone in the lounge. We observed them for half an hour before a member of staff came to see if they were all right. The person was sat looking at an empty plate with their hands clasped. The member of staff who checked on them commented their toast was on the floor and that the member of staff who had given them their breakfast this morning never sat with them to support them.

However, they did not offer the person any extra toast to replace that which had been put on the floor. This person's care plan showed that they were nutritionally at risk with a body mass index which put them in the underweight category. In addition, we saw that staff did not always follow the care plan when supporting people. An example of this was a member of staff using the wrong size spoon to support a person to eat. This meant that there was an increased risk of the person choking as they may have too much food in their mouth to swallow safely.

Furthermore, not every effort was made to encourage people to eat. An example of this was when an administrative staff member came to help support people with their meal. They returned after a while to say that the person would not eat. A member of staff suggested that it was probably because the person was not used to the administrative staff. They said, "Try him on a yoghurt. We'll write down that he refused to eat." There was no attempt made for a member of staff they were familiar with to support them person or to entice them with another texture or taste of food. This person's family raised concerns with us that they had lost significant weight in the four months they had been at the home. This was confirmed by their care plan. While action had been taken and fortified drinks had been prescribed by the doctor this had not stopped the decline in the person's weight.

This was a breach of regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and Hydration needs.

Where people may have been unable to swallow safely their needs had been reviewed by an appropriate healthcare professional. Care plans recorded the advice from these professionals on the type of food people should be supported to eat. An example of this was a person who needed a pureed diet.

People told us that they had been supported to access healthcare when needed. One family member told us, "[Name] had the Parkinson's nurse recently and gets an annual check-up with the Parkinson's consultant who assesses his dementia too." A person living at the home said, "They got the doctor in quickly when I had a bad chest. I get the chiropodist coming in and the carers do my fingers. They come in to wash my hair in bed."

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions

had been updated where necessary. Records showed other healthcare professionals such as GP's had been included in people's care when needed.

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were generally kind and caring but there were exceptions. One person living at the home told us, "I find them very caring." Another person said, "Some are nicer than others." Some of the family members commented on the lack of engagement from staff and felt that low morale was an issue. One family member told us, "They [staff] don't come and chat with us nowadays. They always seem down." Family members told us that they were able to visit at times which were convenient for them and were able to bring their pets to cheer people up.

Some people had 'Knowing you' booklets completed in their care plans. These contained information about the person's home life and background and helped staff to get to know people better. This is important for people with dementia as it supports staff to know which part of their lives they can recall and gives staff topics of conversations to help build relationships. However, these booklets had not been completed for all people.

Staff told us that use of agency staff impacted on people living at the home and increased the levels of distress as people did not recognise the staff caring for them. An example of this was recorded in one person's care plan. It noted that they would sleep in their bed when regular staff were on duty. However, they reacted to strange people caring for them and would refuse to go to bed and sleep in a chair in the lounge.

People voiced some concern over a lack of person-centred care, with family wishes also not always being respected. We observed staff being task-led much of the time and spending no quality time with people. However, we did see some individual staff providing good care which showed they understood how to communicate with people living with a dementia. For example, one member of staff supported a person to sit safely in their chair. We saw that they went down to the person's level, gained eye contact and said the person's name to get their attention. When they had done this the person had listened to the member of staff and sat further back in their chair keeping them safe from falling.

Staff did not always display a caring attitude to people. For example, we heard one member of staff comment to a person that the night staff had not put their glasses on for them. However, the member of staff did not offer to fetch the glasses for the person. We also saw that at 4pm staff made themselves a hot drink and sat in the lounge area to drink it while completing paperwork. However, they did not offer drinks to the people in the lounge, although they did make a fresh drink for one person who asked them. In addition they did not encourage this person to drink which was important as they had not drank their previous hot drink either.

We saw the lunch experience was not as pleasant as it could be. In the main dining area the tables were bare and not laid with cutlery and there was no menu on show to let people know the choices. People were not given the opportunity to personalise their meals as they were plated up in the kitchen. Staff did not interact with people when serving their meals. For example, they did not tell people what the meal was when it was placed in front of them.

There had been a machine breakdown in the laundry and no material aprons were available for people. However, staff did not offer people plastic aprons and there were no serviettes for people to use. Therefore, when people dropped food down their clothes they had no way of cleaning it up.

Where people were clearly able to tell staff their wishes, they were able to make choices about their care. For example, one person told us, "It's up to me; I stay in my bedroom or can choose the lounge." However, family members raised concerns that at times people were not given the time to make choices. One family member told us, "She doesn't get many chances even though she can say if she wants a drink. They assume she won't reply." In addition, families also told us that not everybody was given the freedom to be out of bed and sit in their room or communal areas. Two families told us that they felt it was easier for staff if a person remained in bed. One family member said, "They were starting to put mum to bed for no reason. We insist she needs to be up in the lounge and not isolated. Our wish is for her to be up and in the lounge. I've come unexpectedly and may find her in bed."

We did find that care plans recorded people's abilities to communicate both verbally and non verbally to help staff understand people's communication. For example, care plans recorded how people could communicate when they were in pain and if they needed pain relief. Where people were unable to communicate care plans recorded the behaviour they displayed when in pain.

Family members raised concerns that their relatives were not supported to maintain the level of appearance they had presented all their lives. One family member told us, "He can often look scruffier than other people as he won't always co-operate with a daily hair wash, which he's always needed with greasy hair, or shower and shave." A member of a different family said, "He used to have a shower but now they just wash him in bed. Sometimes I have to shave him as I'll find him bristly, they don't do him every day." They also told us, "Things go missing in the wash. He's got plenty of shirts but we've found him with the same one on four days in a row before." A third family said, "She has a bed bath and gets regular hair washes. We brought loads and loads of clothes when she came in and half have disappeared or been ruined in the wash. We take her jumpers home to wash now. Dad gets upset when he comes in and finds her in someone else's clothes."

People told us that staff generally respected their privacy and dignity. We observed staff knocking on doors before entering and adjusting clothing of several people in communal areas. One person told us, "They [staff] always knock. I do my own curtains if I'm dressing." However, one person living with advanced dementia was walking around in just their trousers with their continence product on show. Staff explained that the person disliked being dressed again and could become difficult so they adopted a hands off approach for this person.

We saw that people had been able to personalise their rooms and that some people that people had their names on the door. However, these were written on scraps of paper and were taped to the door. It was not attractive and did not enhance the environment or support people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Most people told us they were happy at the home. One person living at the home said, "I'm happy, everyone is friendly and we all mix." Another person told us they were, "Fairly happy, I suppose." People received a full assessment before moving into the home. This was to ensure that the home and staff were able to meet people's needs and that appropriate equipment was available to support them. Care plans recorded how people should be supported with their personal care and how many staff were needed to support them safely.

However, care was not always provided to meet people's needs or planned to minimise people's distress and to help them have a calm happy day. We saw one person was reluctant to receive personal care and became distressed when staff tried to help them with things. This person was in the lounge in their night clothes. It was 11:30 am before staff offered the person an opportunity to get dressed, at which stage the person became distressed about having to receive care. Record showed this person needed two or three staff when receiving personal care due to their distressed reaction. We saw the lady was eventually taken to her bedroom to get dressed. However, this was with two members of staff escorting her and ignoring her wishes. We discussed with the nurse why this person had not been assisted to dress when they had got up as it would be less distressing for them. The nurse said that was the usual routine for this person. However, night staff had not followed the care plan and this person had been sitting in the lounge since the night staff left duty at 7am.

This person's distress continued at the midday meal when they were given stew and chips for their lunch. This person's notes recorded that they could be self-sufficient with finger food and this would prevent them being distressed.

We saw that other people were not supported to be settled and happy. One person spent most of the day, walking around the home and trying external doors to get out. We saw at one stage they were very distressed and in their reality were upset as their dog was missing and they were worried about them and were trying to get outside to find them. While the dog was safe at home with the person's family, staff did nothing to reassure the person that their pet was safe. There was an acceptance that this exit seeking and distressed behaviour was part of the person's dementia. No action had been taken to identify the care needed to help the person feel settled and worry free. A member of their family told us, "He's left to wander. They'll give him a drink and sandwich to settle him sometimes."

Record showed where people's needs had changed care plans had been updated to reflect the changes needed. However, although care plans contained the information needed to care for people safely staff told us they did not read the care plans. One member of staff told us, "We should read care plans but we don't get the chance when we come on shift. We get assigned tasks and there's no time to look at the care plans."

People and their families had not always been included in planning the care they needed and had to ask for opportunities to discuss care. One family member told us, "I've had no meetings here. I have to do the asking if I want to know something. If I ask the nurse, she'll tell me." A member of a different family said,

"Dad and I have got LPA (lasting power of attorney) for her and we have to instigate any meeting. I ask to see her care plan. They invited dad in once to sign it." A lasting power of attorney is where a person has legally identified who they want to make their decisions for them when they are no longer able to make them.

Activities were supported in the home by an activity coordinator four days a week for eight hours a day. In addition, a member of staff told us, "If Activities aren't here, we'll try and get 15 minutes with people in the afternoon if we can, it all depends how things are going." Care plans recorded if people needed one to one time with the activities coordinator to support the people to remain engaged with activities. However, we found that people were not fully supported with activities and that activities were not used to help people be settled and happy. Although a noticeboard identified some daily activities, we saw no evidence of any activity taking part. Much of the time, people were unsupervised in the lounges, with television as the sole stimulation.

People living at the home told us about activities they had taken part in. One person told us, "I've joined in some of the things or they'll ask me to, else I watch television in my room. We have a bus for trips sometimes." Another person said, "There's only something on now and then. I'll join in and if there's any outing going, I'll go. I still like writing and drawing and listening to music." However, we observed this resident was sitting in the lounge from mid-morning to mid-afternoon with no activity or stimulation other than the television.

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

People told us they knew how to raise a complaint. However, families who had raised concerns with staff did not always feel that issues had been resolved. One family member told us, "My daughter has complained about the lack of general care and washing [name]. She told the nurse and threatened to go to head office. It changed for a bit, but he still had the same shirt on for three days yet again." Another family member told us, "We know what the procedure is but we've just done verbal ones on things we want to point out. We don't see much done though." We discussed this with the operations manager, who found that no formal complaints had been raised. However, there was no recording of the informal complaints people had raised or any action taken to resolve the concerns.

Requires Improvement

Is the service well-led?

Our findings

At previous inspection dated the 15 December 2015, we identified that the key questions of safe, effective and well led required improvement. We particularly noted in the well led section of our report that that registered manager was not responding to concerns raised by the staff and was not supportive. In addition, we noted that recruitment of new staff was not happening in a timely fashion.

At our inspection on 30 January 2017 we found that there had been no improvements in the safe, effective and well led key questions and that standards had slipped from out last inspection so that there were now breaches in regulations. In addition, we found that the low standard of management had let the two previously key questions rated as good become requires improvements. One visitor told us, "Staff talk to me and told me they're leaving due to the manager. It was ten out of ten for the first 18 months. The last six months with the new manager, the care hasn't been the same. A lot of good staff left, so new ones are still learning. Now it's five out of ten and a lot of improvement needed."

People told us that the registered manager was not generally visible or approachable. One person living at the home told us, "I'd talk to any of the staff instead." Another person said, "I've not seen him much." A family member told us, "I've never seen him here and never had a meeting or chat."

The registered manager was not available on the day of our inspection. Staff were supported by an operations manager. We raised our concerns with the operations manager. They told us that the registered manager had been found to be ineffective and would not be returning to duty. They explained that despite ongoing support the registered manager had failed to manage the home effectively. A number of staff had contacted the provider's whistle blowing telephone service to raise their concerns. In addition, they told us that action would be taken against the deputy manager for not completing their duties properly and providing leadership for the home. Following our inspection the operations manager contacted us and told us that that the registered manager and deputy manager had been replaced.

Staff told us that they were supported by monthly meetings. However, they told us they didn't find these constructive and that staff would often lose sight of what they were trying to achieve. They said there was a lot of staff who did not get on with each other and that this had an effect on people living at the home. One member of staff explained how they never got the chance to talk about how they could alter the care to meet people's needs in these meetings. They told us they would like staff to be more supportive to each other and for there to be a more positive attitude within the home. In addition to the care staff meetings the nursing staff also had a monthly meeting to talk about any concerns they had.

There was a lack of leadership in the home. Care staff told us that they did not feel they got a lot of guidance from the nursing staff. Apart from one nurse who would organise the shifts and allocate people tasks. If this did not happen there were members of the care staff who would try to manage the shift and this did not work. Staff meeting minutes from 30 November 2016 showed that staff were not sticking to their assigned tasks and would swop their working areas during the shift so they would work with staff they preferred.

Monthly audits had been completed in the home. However, we saw that all the audits had been completed by the registered manager. For example, the monthly kitchen audit which should have been completed by the head chef and the environment audit which should have been completed by the housekeeper. Therefore there was no double checking that audits were identifying concerns and all the power to make changes were held by the registered manager. In addition, we saw that care had not been taken when completing the audits. An example of this was seen in the kitchen audit where the registered manager had ticked that there were signs of a pest infection in their audit dated 5 December 2016. There was no record of the action taken in relation to this. The accidents and incidents were meant to be reviewed on a monthly basis to identify trends. However, these had not been completed.

The operations manager completed a monthly audit which had identified the concerns in the home. There had been on-going supervision and interventions with the registered manager to try to improve the quality of care at the home. However, the interventions had not been effective and had been unable to halt the decline in standards that people living at the home experienced. The operations manager told us that there are a number of investigations regarding the registered manager underway.

The provider had not encouraged staff to complete training, as they were required to do it in their own time and did not get rewarded for this time. In addition they needed have access to a computer outside of work as there was no computer available in the home they could rely on being available for them. The provider had an 'award winning creative minds' training programme all about supporting people with dementia to live their lives to the fullest. However, this ethos was not visible in the home and the provider had not created an environment where staff were able to put their training into practice.

People living at the home and their relatives had not been asked to complete a quality assurance questionnaire in the last year. However, independent of the registered manager one of the nurses had started a Friends of Ashfield Lodge group. This consisted of relatives and people from the local community. They organised activities within the home and supported the home with fundraising and entertainment. One family member told us, "They started a Relatives' club. I came to one meeting and even made a friend there, who's been a big help to me to share problems. A few things happened as a result of the meeting, like fund raising for garden pots."

People's privacy had not always been respected. We saw some of the care plans had been typed up. The nurse told us they have no access to a computer at work. They thought that these care plans had been taken home by another member of staff and typed up on their home computer. This was a breach of data protection of confidentiality.

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

The operations manager told us they would take action to ensure that all care standards improved and that all on-going monitoring would be completed when the new manager was in post. We saw that they were taking immediate action to improve the quality of care provided whenever they found issues within the home. For example, staff told us there was never enough glasses or cups and people don't always like drinking out of plastic beakers. They told us that were not enough crockery or linen of an acceptable standard. The operations manager told us that they had spoken to kitchen and cleaning staff and had taken immediate action to ensure they ordered whatever they needed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people received appropriate care which met their needs and reflected their preferences. Care was not designed to meet people's individual needs, people and their representatives were not included to the maximum extent in making decisions related to care. Regulation 9(1(a)(b)(c) 3(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that staff always gained consent before providing care and did not ensure that people's rights under the MCA (2005) were protected. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was provided in a safe way for people using the service. They did not ensure that care was delivered in a way to mitigate risks. The management of medicines was not always safe and proper. Regulation 12(1)(2)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that people's nutritional and hydration needs were met by. People were not always adequately supported to eat and drink. Regulation 14(1) (4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure that systems to assess, monitor and improve the quality and safety of care, or systems to assess, monitor and mitigate risks to people were effective. They did not ensure that records were kept safely. They did not seek and act on feedback from people using the service. Regulation 17(1)(2)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there sufficient numbers of suitably qualified, competent and skilled staff to care for people. Staff were not supported to receive appropriate support, training, professional development, supervision and appraisal to enable them to carry out their duties. Regulation 18 (1)(2)