Healthcare Homes (LSC) Limited

Ashley Gardens Care Centre

Inspection report

419 Sutton Road
Maidstone
Kent
ME15 8RA

Tel: 01622761310

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30 June 2022
01 July 2022

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14 October 2022

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ashley Gardens Care Centre is a residential care home providing accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury to up to 89 people. The service provides support to older and younger adults with dementia needs. At the time of our inspection there were 84 people using the service.

Ashley Gardens Care Centre is a purpose-built care home which accommodates the people living there across three separate floors, each of which has separate adapted facilities. People had their own bedrooms and toilets. There are also shared bathrooms, eating and living spaces on each floor.

People's experience of using this service and what we found
Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. People's medicine support was not always being managed safely. Staff did not always have necessary knowledge or skills to meet people's needs safely. Lessons were not always learned when things had gone wrong, to help stop them happening again.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Quality assurance and governance systems were not effective in making sure risks to people's safety were identified and managed safely. Systems had not ensured people received good quality care or people's care records were accurate and up to date. Staff did not always understand and fulfil their expected roles and responsibilities. Some staff gave negative feedback about the culture of the service, saying they did not always feel well-supported or listened to by the provider.

The service was hygienic and infection control measures were being manged to help prevent the spread of infection. Some people's relatives told us they were happy with the support their family members received.

After our inspection, the provider gave immediate assurances about actions being planned and taken by staff in partnership with other health and social care professionals regarding unsafe care and risk management issues we identified. This included submitting a plan of actions telling CQC about actions they had or planned to take to ensure immediate risks of harm to people were reduced.

The provider immediately voluntarily suspended admissions of new residents to the service and invested additional resources to support improvements. We have continued to meet with the provider weekly to discuss their progress in making improvements. The local authority enforced an embargo on any new admissions to this service on 08 July 2022.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 29 March 2022).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to abuse and improper treatment, medicines, falls and choking risks and staffing. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashley Gardens Care Centre on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to abuse and improper treatment, safe care, staffing and governance.

On 11 October 2022 we imposed conditions on the provider's registration. These conditions told the provider how they must act to address concerns regarding fire safety and unsafe care for people with choking and/or aspiration, complex eating and drinking, falls, behaviour that may challenge, diabetes, skin integrity, hydration and personal care support needs at Ashley Gardens Care Centre.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ashley Gardens Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors and an assistant inspector.

Type of Service
Ashley Gardens Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashley Gardens Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 30 June 2022 and ended on 13 July 2022. We visited the location's service on 30 June and 1 July 2022.

What we did before the inspection
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us by the provider since the last inspection and by the local authority and other agencies and health and social care professionals. This information helps support our inspections. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with five support workers, four nurses, one health care practitioner, the chef, the interim deputy manager, the registered manager and the divisional director.

We spent time observing people's experience of receiving care from staff. We reviewed a range of records. This included people's care and medication records and records relating to staffing and the management of the service.

After the inspection
We continued to review care and management records and seek clarification from the provider to validate evidence found. We spoke with the registered manager and nominated individual via telephone.
We spoke with and received feedback from health and social care professionals who regularly worked with staff and people at the service. We spoke with two relatives of people who lived at the service via telephone.
The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Due to the level of concerns we identified, we sought immediate assurances from the provider regarding actions being taken to reduce risk to people at the service. The provider voluntarily suspended admissions of new residents to the service and invested additional resources to support improvements. We have continued to meet with the provider weekly to discuss their progress in making improvements. The local authority enforced an embargo on any new admissions on 08 July 2022.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people and learn lessons when things had gone wrong. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

●Risks to people's health and welfare were not always assessed, monitored and managed safely. At our last inspection we found that risks associated with people's choking and aspirations, complex eating and drinking, falls, behaviours that may challenge and fire safety support needs were not being managed safely. Following the previous inspection, the provider had sent CQC an action plan on 11 May 2022 telling us what they would do to make improvements by 30 July 2022. Although the provider's anticipated completion date was prior to our visit dates, at this inspection we found these areas of people's support continued to be significantly unsafe and there was little evidence the quality of their support had improved. We identified the safety of people's support had deteriorated further and that risks associated with people's diabetes and personal care were now not being monitored and managed safely.
●Since the last inspection there had continued to be a high number of people falling, resulting in serious injuries including bone fractures and head injuries. Reviews of people's falls and mobility care records and risk assessments had not always been completed effectively, or changes made, in response to help keep people as safe as possible.
●Where actions had been identified to reduce the risk of people falling again, there were not always understood or being followed by staff. For example, following a fall and sustaining a serious injury, staff were not ensuring a person was using mobility equipment and were monitored when moving around.
●Some falls and injuries had occurred as a result of staff not knowing how to use moving and handling equipment correctly. People's care plans continued not to have enough detail to explain how to support them safely when using manual handling equipment. People's manual handling equipment was not always stored in an accessible manner as per directions in their care plans and some staff did not know where to locate it correctly. Staff we spoke with continued not to know how to use this equipment and told us they supported the same people to use it in different ways. This increased the risk these incidents would happen again.
●There were a high number of people who needed support to manage choking risks when eating and drinking. Since the last inspection there had been two further choking incidents at the service involving the

same person. Some staff remained unaware of the safest way to reduce the risk of people choking. During our visits we observed staff not following agreed actions to prevent people choking when eating. This placed people at high risk of harm to their health and well-being.

●People had not been assessed on an individual basis to check if it was safe for staff to use a suction machine to help them remove food in the event of a choking incident, although staff had attempted to use a suction machine unsuccessfully on one person during a recent choking incident. Some staff told us they would continue to attempt to use a suction machine if someone choked and some staff said they would not. We checked and not all available suction machines were ready for use. This increased the risk people may receive unsafe support.

●Staff were not consistently completing food and fluid monitoring and weighing charts for people who needed them to check they were having enough to eat and drink. Some people's fluid charts showed they were having very little to drink and some people's food charts did not specify if food they had eaten was of a safe consistency. It was not possible to confirm if these people had been supported as required to safely manage risks of choking or dehydration.

● Risks associated with people's behaviours that may challenge continued not to be assessed, monitored or managed safely. Staff continued to use unauthorised physical and environmental restraint techniques when people displayed behaviours that may challenge, despite not having training or detailed care plans and risk assessments to know how to do this safely. Staff did not consistently complete monitoring charts when behaviours that may challenge, to allow for it to be checked that people were being supported safely when people became distressed. This increased the risk of harm to the person, other people and staff.

● Fire safety risks continued not to be managed safely. Fire checks and fire risk assessment reviews and actions were not being completed as per the providers' policies. This increased the chance equipment and alarm systems may not operate effectively to help prevent harm to people's well-being and health in the event of an emergency.

●Risks associated with people's diabetes and personal care support needs were not being monitored and managed safely. There were inconsistencies in one person's diabetes care plans about the support they needed to safely manage their conditions. This person's diabetes monitoring charts showed extended periods were their blood sugar levels were unsafe. Staff had not recorded they had taken any action during these periods to reduce the risk of harm to the person's health. There had been three consecutive days where the person had not received their insulin medicine to help control their diabetes which placed them at serious risk of harm to their health.

●Staff were consistently recording across several different monitoring charts and daily notes that they were not supporting people to receive continence or oral health care support as often as directed in their care plans and risk assessments. This increased the risk of people experiencing pressure sores and mental health and mobility issues.

●Several people's own bathrooms did not contain toothbrushes or toothpaste and some people were not using their dentures, for unexplained reasons. This increased the risk of people experiencing oral and secondary health infections.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA or, if needed, appropriate legal

authorisations were in place to deprive a person of their liberty. During our visit over half of the 84 people living in the home were being cared for permanently in bed. There was no record of any assessments of people's capacity to consent to this decision and no meetings had been held to decide if this was in people's best interests if they lacked capacity.

●Staff we spoke with, including the registered manager, could not tell us the reason why all of these people were being supported in bed all the time. Some people who were being cared for in bed had care plans that said they should be supported to leave their beds for personal care and social activities.

●Medicines were not always managed safely. Some people's 'as and when' (PRN) medicine protocols continued to lack detail about how and when to give this to people. We observed that staff were not offering people's pain relief PRN medicines as per their prescription directions. This increased the chance people may not get their PRN medicines at the right times or that they may be having too much of them.

●Since the last inspection there had been a high number of reported abuse allegations involving people not receiving their medicines as intended due to staff not giving them correctly. We identified further errors during this inspection where one person had not been given their diabetes medicine as prescribed, and the provider had not been aware of this. This placed people's health at potential risk of harm.

●Medicines were not always stored correctly. People's prescribed eye drops and topical creams had not been signed or dated on opening, which increased the risk that people may be receiving medicines that were not effective.

The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, ensure lessons were learnt or ensure staff had the right skills and experience to safely meet people's needs. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●All of the above issues were immediately fed back to the provider during and after our visits to ask them to act to address them without delay.

●After our inspection, the provider gave immediate assurances about actions being planned and taken by staff in partnership with other health and social care professionals regarding unsafe care and risk management issues we identified. This included submitting a plan of actions telling CQC about actions they had or planned to take to ensure immediate risks of harm to people were reduced.

●The provider immediately voluntarily suspended admissions of new residents to the service and invested additional resources to support improvements. We have continued to meet with the provider weekly to discuss their progress in making improvements. The local authority enforced an embargo on any new admissions to this service on 8 July 2022.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Systems and processes to keep people safe from abuse and improper treatment continued not to operate effectively. Since the last inspection there had been four allegations made by staff and relatives regarding staff subjecting people to physical and psychological abuse and neglect. One of these allegations had been substantiated and others remained under investigation by the provider.

●During this inspection we identified risks and concerns relating to safeguarding. Neglect incidents had

either not been reviewed or had not been adequately acted on by the provider regarding choking, behaviours that may challenge, personal care, diabetes and falls. This included incidents where people had sustained serious injuries by falling or needed to be reviewed in hospital after choking.
● During this inspection we found people were at continued risk of unauthorised restraint. Actions developed to help prevent safeguarding incidents that had occurred since the last inspection had not all been implemented or communicated effectively by management at the service to ensure they did not happen again.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staffing rotas continued not to be managed safely. Despite increased presence of nurses deployed on each floor since last inspection, rotas had not always been managed effectively to ensure there were enough knowledgeable or skilled staff deployed on each shift to ensure people's needs were met as safely as possible.
●The registered manager and provider had increased management observations and supervision of staff since the last inspection however, these had not addressed essential clinical areas of practice. The registered manager told us this was a likely factor in the repeated poor delivery of care and safety incidents at the service.
● There continued to be high number of agency staff working at the service due to on-going staff vacancies. Staff we spoke with, including the registered manager, told us these staff were not always competent or knowledgeable and there was confusion amongst the staffing team over whose responsibility it was to ensure agency staff performance was supervised effectively.
●Although further training was planned to be delivered to address staff knowledge gaps, we observed, and staff told us they did not always know how to meet people's needs safely.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The provider was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure good governance. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care, Working in partnership with others

- Internal quality assurance systems and processes to audit or review service performance and the safety and quality of care had continued not to operate effectively. Increased systems of audits and on-site supervision of staff and management had been introduced since the last inspection. Improvements had been made regarding submission of statutory notifications, and a previous breach of CQC Registration Regulations 2009 had been met. However, despite this, action plans to address previous breaches of regulations found at the last inspection had not been overseen or acted on to effectively improve or resolve serious quality and safety issues.
- Multiple breaches of regulations had re-occurred since the last inspection, placing people at actual and avoidable risk of harm to their health and well-being. There had been several avoidable safety incidents resulting in serious injuries and risks to people's health and well-being.
- The provider's governance framework continued not to be effective in ensuring staff at all levels were aware of their responsibilities and that a good standard of care was sustained at the service and relevant legal requirements were met. People continued to be at risk of abuse and unsafe care. People's care plans continued to contain inaccurate and out of date information about how to safely meet their individual needs.
- The provider's management team had not ensured that all actions and recommendations identified by health and social care professionals to ensure people achieved good outcomes were communicated to and understood by all staff. For example, staff were still not following recommended eating and drinking guidelines. In some instances, people had not been referred for re-assessment with speech and language therapists in a timely manner, to reduce avoidable risks of their choking.

The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics, How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had developed a set of values they expected staff to embody when supporting people. These had not changed since our previous inspection and included offering dignified and respectful person-centred care to people. However, our findings at this inspection confirmed not enough improvement had been made to ensure staff understood and displayed these values and training principles when carrying out their roles.

●Some staff told us they did not feel supported by the provider and there was low morale within the existing staff team. One staff member said there was not enough commitment from the existing staff due to lack of support from the provider. They said, "This is not a good company to work for". Another staff member raised concerns about the way the registered manager communicated about issues, or managed staff performance which affected their morale.

●It was not evident people were being supported in a person-centred and inclusive way, to empower them to achieve good outcomes. It could not be confirmed that over half of the people living at the service at the time of the inspection were being supported according to their individually assessed needs and wishes, or in their best interests, regarding being nursed permanently in bed.

●People's daily notes did not record they were being consistently supported with meaningful activities as defined in their care plans, inside or outside of service and we observed this to be the case during the two days we visited. The physical environment of the service was not suitable for people living with dementia and lacked person-centred adaptations such as signage and decoration to help people make their own decisions and move around as independently as possible.

The failure to ensure records related to the provision of support for people were adequately maintained and service performance and delivery was evaluated and improved is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●Two relatives we spoke with told us they were happy with the support their family member received at the service. One relative told us the registered manager communicated with them in an open manner and they felt they had opportunities to be involved in the delivery of support at the home. The registered manager was aware of their responsibilities under the Duty of Candour and kept a log of emails they had sent on some occasions to relatives where there had been an accident or incident to let them know it had occurred.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and manage risks to service users' health and safety, provide safe care and treatment, manage medicines safely, ensure lessons were learnt or ensure staff had the right skills and experience to safely meet people's needs. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

On 11 October 2022 we imposed conditions on the provider's registration. These conditions told the provider how they must act to address concerns regarding fire safety and unsafe care for people with choking and/or aspiration, complex eating and drinking, falls, behaviour that may challenge, diabetes, skin integrity, hydration and personal care support needs at Ashley Gardens Care Centre.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

On 11 October 2022 we imposed conditions on the provider's registration. These conditions told the provider how they must act to address concerns regarding fire safety and unsafe care for people with choking and/or aspiration, complex eating and drinking, falls, behaviour that may challenge, diabetes, skin integrity, hydration and personal care support needs at Ashley Gardens Care Centre.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Treatment of disease, disorder or injury	governance The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

On 11 October 2022 we imposed conditions on the provider's registration. These conditions told the provider how they must act to address concerns regarding fire safety and unsafe care for people with choking and/or aspiration, complex eating and drinking, falls, behaviour that may challenge, diabetes, skin integrity, hydration and personal care support needs at Ashley Gardens Care Centre.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

On 11 October 2022 we imposed conditions on the provider's registration. These conditions told the provider how they must act to address concerns regarding fire safety and unsafe care for people with choking and/or aspiration, complex eating and drinking, falls, behaviour that may challenge, diabetes, skin integrity, hydration and personal care support needs at Ashley Gardens Care Centre.