Ashley Down Care Home Limited

Ashley Down Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Ashley Down Nursing Home on the 22 and 24 November 2016 and the inspection was unannounced. Ashley Down Nursing Home provides accommodation for up to 19 people over the age of 65 that may require nursing and personal care and support, some of whom living with dementia or a physical disability. The accommodation is provided in an older style detached house in a residential street. There is a communal lounge, dining room, kitchen, communal bathrooms and bedrooms with en-suite bathrooms. Outside there is a good size garden that people have access to. There were 16 people living in the home on the days of our inspection.

The provider was also the registered manager, who was in day to day charge of 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.

At the last inspection undertaken on the 07 January 2016, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to staffing levels; recruitment practice, the provision of meaningful activities, management of complaints, notifying CQC of significant events and improving their quality assurance framework. The provider sent us an action plan stating they would have addressed all of these concerns by June 2016. At this inspection we found the provider had made improvements to safe recruitment practice but the provider continued to breach the regulations relating to the other areas.

Systems in place to assess the quality of the service provided were not always effective and had not consistently identified shortfalls in the provision of care and quality. Care plans were not consistently fit for purpose and lacked personal information on people's likes, dislikes and what was important to them.

The principles of the Mental Capacity Act (MCA 2005) were not embedded into practice. Appropriate processes in regard to mental capacity assessments had not been followed for the use of potentially restrictive care practices such as bed rails and wheelchair lap belts.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS applications had been made to the local authority and had been approved. However the registered manager had continued to fail to notify CQC of the authorisations. DoLS care plans were not in place.

The risk of social isolation had not been addressed or mitigated. People had no access to stimulation or meaningful activities. Insufficient staffing levels and deployment of staff meant staff had no time to provide activities or one to one chats with people. A visiting relative told us, " I have no complaint apart from the fact there is little to do but I understand they are recruiting; you'd think they would think of something in the

meantime though, it doesn't take much to start a sing-along for example. I guess they are too busy to do that, they have so much to do."

The management of continence required improvement. Large gaps in documentation reflected that people could go up to seven hours without support to meet their continence needs. Staff told us they received essential training that equipped them with the skills to meet people's individual care needs. The provider had failed to identify that training had not been provided on the safe and effective management of diabetes, epilepsy and pressure care. We have identified this as an area of practice that needs improvement and have made a recommendation about reviewing the formal provision of training based on best practice guidelines and people's individual care needs.

The risk of skin breakdown for people had been assessed, however, where people received care on an air mattress, documentation failed to record that the setting was regularly checked. We have identified this as an area of practice that needs improvement and have made a recommendation about the monitoring and oversight of air mattresses.

Where people had lost weight or their blood sugar level had not been monitored, documentation did not consistently reflect what action had been taken and why. A complaints policy was in place but the provider had failed to update and review the policy since the last inspection in January 2016 when it was identified the policy was not fit for purpose. The management of risk across the home was not consistent and risks to people's safety had not consistently been mitigated.

Risks associated with the environment were not consistently up to date. The provider operated a stay put policy in the event of a fire. For people living on the first floor of the home, in the event of a fire, they would be unable to be evacuated as evacuation chairs were not in situ. We have made a recommendation about the review of their internal fire risk assessment and procedures.

People were supported to receive their medicines on time by qualified and competent staff. Medicines were managed and stored appropriately. People were supported to access health services and their health care needs were being met. People were safe and staff knew what actions to take to protect them from abuse.

Staff treated people with kindness and compassion. One staff member told us, "The residents are wonderful." People spoke highly of the food provided and where people required one to one support with eating and drinking, this was provided in a kind and gentle manner.

Training schedules confirmed staff had received safeguarding training and demonstrated a firm awareness of the actions to take to people safe from harm or abuse. Recruitment practice was safe. Risks associated with the environment were managed and the provider was making arrangement to make the environment more dementia-friendly.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If sufficient improvement is not made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

During our inspection we found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Ashley Down Nursing Home was not safe.

Staffing levels were not based on the individual needs of people. The deployment of staff was not always sufficient to keep people safe

Where people were unable to use their call bells, robust risk assessments were not consistently in place.The management of risk across the home was not consistent.

Medicines were managed appropriately and people confirmed they received their medicines on time. Recruitment systems were in place to ensure staff were suitable to work with people. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

Ashley Down Nursing Home was not consistently effective.

The principles of the Mental Capacity Act (2005) were not embedded into practice Restrictive practices were taking place and the provider was unable to consistently demonstrate if these restrictive practices were lawful and in line with legislation.

People's dining experience was varied but people spoke highly of the food provided. Any dietary requirements were catered for.

Staff received one to one supervision sessions and appraisals, however staff had not consistently received essential training to meet the individual needs of people they supported.

Is the service caring?

Requires Improvement

Ashley Down Nursing Home was not consistently caring.

Improvement was required to meet people's continence needs in a timely manner.

Staff spoke with compassion and pride for the people they supported. Visiting times were not restricted and relatives visited throughout the day. People were supported to maintain relationships with people who mattered to them.

People were supported to maintain their identity. Bedrooms were personalised and a hairdresser visited the service regularly.

Is the service responsive?

Inadequate

Ashley Down Nursing Home was not responsive.

People did not have access to meaningful activities.

Care plans were not personalised and failed to record information on people's likes, dislikes and what was important to them. The complaints policy and procedure had not been reviewed to provide sufficient information to complainants.

People's care needs had been assessed and a care plan formulated. Systems were in place for people to provide feedback on the running of the service

Is the service well-led?

Inadequate

Ashley Down Nursing Home was not well-led.

The service undertook regular quality audits however these did not identify issues found during the inspection. The provider had not acted to meet breaches in regulation that had been identified at our previous inspection.

The provider did not have effective systems and processes in place to help monitor the quality of care people received. Systems were not in place to demonstrate how continual improvements were being made.

Not everyone was consistently aware who the registered manager was.

Ashley Down Nursing 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.

The inspection took place on the 22 and 24 November 2016 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor with knowledge of older people's care, 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.

On this occasion, we had not asked the provider to complete a Provider Information Return (PIR). 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. Before the inspection we checked the information that we held about the home and the provider. This included previous inspection reports and 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 to us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people, three visiting relatives, three care staff, the registered nurse and registered manager who was also the provider. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at ten care plans and associated risk assessments, three staff files, medication administration record (MAR) sheets, incidents and accidents, policies and procedures other records relating to the management of the service. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's received and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We last inspected Ashley Down Nursing Home on the 07 January 2016 where it had a rating of Requires

Improvement.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Ashley Down Nursing Home. One person told us, "I feel safe because the staff are good and they talk nicely to me." Another person told us, "I feel safe here because no one can get in. I do like the staff and my room is nice." However people unanimously commented that the home required more staff.

At our last inspection in January 2016, the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. These was because staffing levels were not always adequate to meet the needs of people, and were not varied to reflect the changing dependency needs of people, and recruitment practice was not safe. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by June 2016. At this inspection, we found improvements had been made in relation to recruitment; however, systems were not in place to ensure that staffing levels were based on people's individual needs, and staffing levels remained an on-going concern.

Systems were not in place to ensure that staffing levels were based on people's individual needs. The registered manager told us, "Since the last inspection in January 2016, we have increased staffing levels. A dependency tool was in place but we haven't been completing that. We know people's needs and the staffing levels required." Staffing levels consisted of one registered nurse throughout the day, three care staff in the morning and two care staff in the afternoon. Staffing at night consisted of one registered nurse and one care worker. Staff members felt staffing levels were sufficient in meeting people's basic care needs. One staff member told us, "Staffing levels seem fine." However, a visiting relative told us, "There is not enough staff they could do with some more." Another person told us, "There is not enough staff." However, in the absence of a dependency tool, the provider was unable to demonstrate how staffing levels were based on people's individual needs and ensured all care needs were met.

The deployment of staff was not always sufficient. On both days of the inspection, we spent time with people in the communal lounge. On the first day of the inspection, six people were in the lounge. On the second day of the inspection eight people were in the lounge. People were left for periods of time with no access to a call bell. Staff popped in throughout the day and we saw that staff supported and encouraged people to drink. However, people were often left unattended for up to and over twenty minutes. This posed a risk to the safety and well-being of people. For example, on the second day of the inspection, one person had been left alone in the lounge. They managed to push themselves along in their wheelchair with a table tray in front of them. This posed the risk of harm as they were at risk of toppling over. When noticed by staff, they told staff they wanted to go to a local town. One person who lived in the home told us how they felt it was their responsibility to look after the other 'residents' sitting in the lounge. They told us, "Sometimes staff bring people into the lounge and expect us to look after them." Incidents and accidents logs reflected that no harm had occurred to people as a result of poor deployment of staff. However, the absence of a formal dependency tool also meant the provider was unable to demonstrate how they assessed this risk when considering and determining staffing levels.

From our observations and feedback from staff and people, people's basic care needs were met. However,

the provider was unable to demonstrate how staffing levels were based on people's individual needs and were responsive to changing dependency, how they ensured all care needs were met, and mitigated risk. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in January 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because they were not following safe recruitment procedures. We found that improvements had been made. Thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable. Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and obtained from the most recent employer where possible. There was a system in place for checking and monitoring that nurses employed at the home had appropriate professional registration.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses, regular re-positioning and application of barrier creams. Staff confirmed that no one was living with a pressure ulcer. Where people required the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage), it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. We were informed the settings of air mattresses were checked daily, however, there was no recording to confirm it was checked and on the right setting. Documentation also failed to record what setting it should be. This meant new members of staff or agency staff may be unaware what setting to check for, and failure to record checks could potentially place people at risk. We have identified this as an area of practice that requires improvement.

We recommend that the provider seeks guidance on the monitoring and oversight of air mattresses.

Before the inspection, we received information of concern that call bells were not readily available for people to access and were reset by staff without assessing whether the person needed assistance. During the inspection, we checked this and found that most people had access to their call bells and the call bells were working. We found for people living with dementia, who had been assessed as unable to use the call bell, there was guidance in the care plan for staff to check them regularly. For example, one person's care plan recorded, '(Person) is unable to use call bell, staff to check on them regularly.' The frequency of checks was not recorded. This was a consistent theme for people assessed as being unable to use their call bell. We asked a staff member how often people should be checked upon. They told us, "Every two to three hours." The frequency of checks was not recorded in people's individual care plans and there was no underpinning assessment to reflect that this frequency of checks was sufficient in ensuring the safety and wellbeing of people. This also meant for new staff members, that this information would not readily be available. We also asked staff where these checks would be recorded. A staff member told us, "The turn charts doubles up as evidence of well-being checks." Turning charts reflected that people were checked upon every two hours to be supported with re-positioning. However, no reference was made to the person's well-being within these charts.

During the inspection, we regularly checked upon people who were unable to access their call bell. We

found one person asleep with their head on their bed rail and pillow on part of their face. Their airways were clear; however there was the risk of the pillow falling over their airways. The person also looked in discomfort. We immediately pressed their call bell as we were concerned of the risk of suffocation. Staff attended immediately and checked upon the person. Documentation confirmed they were checked upon two hours ago. However, there was the risk this person had been in this position for up to two hours.

The risk of people being unable to use the call bell had been assessed. However, the provider had failed to fully evidence and demonstrate that the frequency of checks was based on the person's individual assessed needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of risk was not consistent or mitigated appropriately. Risk assessments were in place which considered areas such as falls, moving and handling, skin breakdown and epilepsy. These were reviewed monthly. However, we found shortfalls in the management of risk. People's risk of malnutrition had been assessed. However, where people's care plans identified to monitor food and fluids, food and fluid charts had not consistently been completed. For example, one person who was unable to eat or drink independently. Their care plan said to encourage and monitor fluids, however a fluid chart was not in place. During the inspection, we observed that they had very dry lips, were unable to press the call bell and their drinks were not within arm's reach. We brought this to the attention of the lead nurse. The absence of a fluid chart meant the provider was unable to demonstrate when the person was last supported to drink. A staff member told us, "The manager doesn't want everyone on a food and fluid chart." Where food and fluid charts had been completed, we could see that staff totalled people's fluid intake at the end of each day. However, where shortfalls were identified in the management of weight loss and hydration needs, documentation failed to reflect that staff were aware of these concerns and why action had not yet been taken.

People's weight was assessed monthly. Most people were maintaining a stable weight and primarily where people had lost weight, we could see what action had been taken. However, we identified two people who had lost weight and documentation failed to reflect what action had been taken. For example, one person had lost 10.8kgs since June 2016. The monthly evaluation notes failed to make reference to this weight loss. We brought these concerns to the attention of the lead nurse who was aware the person had lost weight and identified the person had been upset recently and they contributed this to the weight loss. However, they confirmed a referral to the dietician or GP had not been made. They were responsive to our concerns and a referral was made during the inspection.

The management of diabetes was not always consistently effective. People living with diabetes have an increased risk of disability, pressure ulcer development and hospital re-admission. A small number of people living at Ashley Down Nursing Home were living with type two diabetes (controlled by diet or medicine). Most people's blood sugars were being checked on a monthly basis to ensure their blood sugar levels remained stable. However, one person's blood sugar level had not been monitored for over three months. We received contradictory answers from a staff member and the registered manager as to the reason why. The registered manager told us that this decision not to check monthly was based on the advice of a healthcare professional. A staff member told us that they knew the person and would be aware if they were unwell due to low blood sugar levels. A protocol or policy was not in place for the management of diabetes and the provider was unable to demonstrate how this decision not to monitor the person's blood sugars monthly was a clinical decision and based on an assessment of the person's needs. Diabetes care plans were also not in place to provide guidance to staff on what the signs and symptoms of high and low blood sugars may be.

Staff had a firm awareness of who was diabetic and what care was required to manage their diabetes. One staff member told us, "We keep an eye on their sugar intake." Documentation confirmed that no harm had occurred to this person and other people's blood sugar levels had remained stable. However, the provider had failed to record and evidence the steps required to safely manage the risks associated with diabetes and provide guidance for staff to follow.

Failure to provide safe care and treatment of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with the safety of the environment and equipment were not consistently identified and managed appropriately. For example, there had been no recent gas safety check and the legionella certificate was out of date. The provider told us that this was being reviewed in the next couple of weeks. In the event of a fire, the provider operated a stay put policy. People living on the first floor would be unable to be evacuated in the event of a fire as fire evacuation chairs were not in situ. All doors within the home were fire resistance and we were informed that they would provide 'an additional 30 minutes of protection.' A fire policy was in situ but we could not locate a recent fire risk assessment from the local fire brigade.

We recommend that the provider reviews their internal fire risk assessments and procedures with a professional body to ensure they met up to date standards and legislation.

Equipment such as hoists and wheelchairs were stored securely and accessible when needed. Regular checks on lifting equipment and the fire detection system were undertaken to make sure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of electrics and food hygiene. A business continuity plan considered what the home would do in the event of a gas failure, severe weather such as snow or a heat wave or the loss of heating.

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. Records confirmed that staff had received training in safeguarding. Staff were able to tell us what may constitute abuse, signs which may alert them to concerns and reporting procedures. One staff member told us, "If I witnessed any staff shouting at residents, I would not tolerate it. I would inform the manager. If they didn't do anything I would go to the local authority or CQC."

Medicines were stored, administered, recorded and disposed of safely. Medicines were delivered from the pharmacy already dispensed in monitored dose packs. People knew what their medicines had been prescribed for and staff sought consent from people before giving them their medicines. We saw that medicines administration record (MAR) sheets were signed when the medicines had been given. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks for medicines stored in the fridge. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

Requires Improvement

Is the service effective?

Our findings

Most people and their relatives told us they felt staff provided effective care and spoke highly of the food provided. One person told us, "The food is excellent; they ask me in the morning what I would like. I have confidence in the staff because they are friendly." A visiting relative told us, "The food is very good. I'm confident in the staff because her quality of care is good. She has put weight on since she has been here." However, despite people's high praise for staff, we found Ashley Down Nursing Home was not effective. For example, one person told us, "No I'm not confident in the staff; they don't know how to care for me. (Staff member) has no idea how to look after me; she doesn't want to do anything."

At the last inspection we identified areas of improvement in relation to staff supervision and improvements to the décor to make it dementia friendly. Recommendations were made and at this inspection, we found improvements had been made. However, we also identified areas of practice where good practice had not been maintained.

People's rights were not always protected because the provider did not always act in accordance with the MCA 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments were in place which considered, 'Can (person) consent to care planning and treatment.' Where people lacked capacity for this decision, the provider had failed to meet with appropriate parties to make a decision on the person's behalf and in their best interests. Where a best interest decision had been made and recorded, a preceding mental capacity assessment had not been completed. A wide range of consent forms were in place which included consent to the use of lap belts, wheelchairs and other restrictive practice. A large majority of consent forms were signed by people's relatives. We asked the registered manager whether relatives had the appropriate authority to sign the consent forms. The registered manager was unaware whether all relatives had appropriate authority. Where relatives did, copies of these had not been obtained. Where family members were making decisions and signing consent forms, the provider had also failed to complete decision specific mental capacity assessments to evidence that the person was unable to make the decision and required their legal representatives or their family members to make the decision on their behalf.

Training records confirmed staff were in the process of receiving MCA and DoLS training. Fifty percent of staff had received training and the other fifty percent of staff were due. Staff understood the importance of gaining consent from people and recognised that people had the right to refuse consent. One staff member told us, "We always give people a choice, such as what to wear and what to eat." However, despite training taking place, we observed the principles of the MCA 2005 were not fully embedded into practice.

A range of restrictive practices were in place, such as key coded entry to the home. This included stair gates, bed rails, lap belts and people sitting in wheelchairs with their lap belt done up and a table placed in front of them. Specific mental capacity assessments for each restrictive practice had not been completed. The

rationale for the use of bed rails was not always clear. For example, one person's care plan made no reference to the need for bed rails. However, we observed this person in bed with the bed rails up. Another person spent the whole day sitting in their wheelchair with the lap belt done up (whilst stationary). Their care plan made no reference to why they needed to spend all day in a wheelchair or the rationale for the lap belt. Throughout the inspection, we observed that whoever spent the day in their wheelchair had their lap belt done up. The rationale for this was not consistently recorded or clear. One person told us, "I think staff just forget to undo the lap belt." The provider could therefore not demonstrate if they acting in accordance with the Act and whether the restrictive practice was lawful.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The inspection team identified one person who was subject to a DoLS but an application had not been made. The provider was responsive to our concerns and agreed to submit the application immediately. Where DoLS were in place, care plans failed to record whether people were subject to a DoLS authorisation and what it meant for that individual. This posed a risk that for new staff members, they would be unaware if a person was deprived of their liberty and of the conditions of the restriction.

Failure to work within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Code of Practice is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and contravenes Article 5 of the Human Rights Act 1998.

Guidance produced by Skills for Care advises that having a competent workforce is essential to providing high quality, person-centred care. It is each provider's responsibility to ensure their workforce has the necessary knowledge and skills to carry out their role effectively. Training schedules confirmed staff had received training in safeguarding, dementia, moving and handling and infection control. The registered manager told us, "All training is face to face, I prefer that to online training." Systems were also in place for staff to obtain health and social diplomas and the registered manager confirmed that two staff were working towards a level two diploma. Staff spoke highly of the training provided. Despite staff's high praise for training, we identified that training had not been provided to ensure staff meet people's individual specific care needs. For example, training on pressure care, diabetes or epilepsy had not been provided to nursing staff and care workers. Although no one had a pressure ulcer, people had been assessed at high risk of skin breakdown. At least two people were living with epilepsy and one person had a recent seizure. In the absence of formal training, staff felt they managed people's needs effectively. One staff member told us, "Where people are at risk of skin breakdown, we have positioning charts in place and apply barrier cream." People and their relatives also raised concerns over the competency of staff. One person told us they felt staff were not competent in meeting their individual needs. A visiting relative told us, "I'm not sure how confident that staff are." Although staff felt competent, the provider had not identified the need for formal training to ensure the delivery of care was based on best practice guidelines and that some people and their relatives felt staff lacked confidence.

We recommend that the provider reviews the formal provision of training based on best practice guidelines and people's individual care needs.

The Social Care Institute for Excellence (SCIE) states that good supervision, be this in the form of observations of staff's practice or formal meetings, should result in positive outcomes for people who use

services as well as the staff. Staff and nursing staff confirmed they received regular one to one supervision and improvements had made since the last inspection in January 2016. One staff member told us, "I get supervision every three months. It's helpful. I can also approach the manager or nurse if I have any queries."

Care and support was provided to a number of people living with dementia. Guidance produced by the Alzheimer's society advises that a safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. At the last inspection, a recommendation was made for the provider to follow good practice regarding dementia friendly environments. Improvements had been made and were on-going. Toilets and bathrooms were clearly labelled in bold print and in picture format. The registered manager told us, "We've also ordered picture frames to be put on all doors at wheelchair level to help orient people. For example, pictures of people will be placed on their bedroom door to personalise the bedroom door. These will be in place next week." On-going improvements were taking place to ensure the design and layout of the home met the needs of people living with dementia.

People had access to healthcare professionals when required. Each person had a multi-disciplinary care record which included information when GPs, dieticians, SALT and other healthcare professionals had visited and provided guidance and support.

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating. People's dining experiences varied. On the first day of the inspection, only six people ate in the dining room. Everybody else remained in their bedroom and one person had their lunch in the lounge. This meant for nine people they spent the day having all their meals in their bedroom. This added to the risk of social isolation. The registered manager acknowledged this was not usual practice and confirmed an investigation would take place to ascertain why so many were not supported to access the dining room. Staff members told us that at least ten people required one to one support with eating and drinking. Throughout the inspection, we observed that this level of support was provided, however, staff acknowledged that due to the high dependency of people at lunchtime it could be a challenge. One person told us at 12:00pm they were hungry and asked for a sweet. Staff gave them a sweet; however, they did not receive their lunch until an hour later. Another person still hadn't had their lunch at 12.45pm. They told us, "I hope it's worth the wait." On the second day of the inspection, improvements had been made and more people were supported to access the dining room and engage with staff and other people during lunchtime.

Despite the above concerns, people spoke highly of the food provided. One person told us, "The food is nice; I do get a choice, I'm on a restricted diet but I can use my money to buy some of the things." A visiting relative told us, "The food is good, they have to feed him, he is cared for in bed and cannot talk." Tables were neatly decorated with condiments, napkins and table cloths. Music was playing softly in the background and staff sat down with people to provide support with eating and drinking. One person had very little to eat at lunch time, however, staff sat down with them again in the afternoon to see if they would like some more. For people living with a swallowing difficultly, input from Speech and Language Therapist (SALT) had been sourced and any specialist diet recommended was provided. For example, a number of people required a soft or puree diet and we saw that this was provided.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about whether they were treated with dignity and respect. People felt they were treated with respect and kindness. One visiting relative told us, "I believe they are caring towards him, he looks clean." However, we received mixed responses as to whether staff respected their privacy and dignity. One person told us, "When they give me a wash they put the screen up." Another person told us, "They give me dignity and respect, when they give me a wash they close the curtains but when I first came here there was a commode in the corner but now they say I'm too heavy so I have to go to toilet in bed." Another person told us, "They don't dry me after my wash."

Staff members told us they understood the importance of protecting people's privacy and dignity. One staff member told us, "We always make sure curtains are closed and when supporting people with a bed bath, ensure they are not exposed." Training schedules confirmed staff had not received training on privacy and dignity. Although staff told us how they respected people's privacy and dignity, in the absence of formal training, staff's competency had not been assessed and consideration had not been given to the impact of continence care on people's dignity.

We recommend that the provider seeks guidance from a reputable source on privacy and dignity training.

The management of continence care required improvement. Guidance produced by the Royal College of Nursing advises that urinary incontinence can restrict leisure opportunities, and lead to social embarrassment and isolation, affecting both physical and mental health. It is vital that people who are incontinent are given every opportunity to regain their continence. High quality comprehensive continence services are an essential part of health care. Upon admission to Ashley Down Nursing Home a continence risk assessment was completed which recommended a toileting regime or how often people required support to change their continence pad. A continence care plan was subsequently implemented; however, it failed to record the frequency of when people should receive support to meet their continence needs. Care plans recorded 'continence pad to be changed as required.' Information was not recorded on the frequency of these checks. Staff members told us that they supported people every three to four hours to change their continence pad. However, we found that documentation reflected that some people went up to seven hours before receiving support to change their continence pad. For example, we identified a strong odour from one person's bedroom. We checked upon one person at 11.55am on the first day of the inspection. Documentation confirmed their continence pad was last changed at 05.20am. Documentation from the 21 November 2016 reflected that they received support at 06.35am with their continence needs and no further support until 14.50pm (eight hours later). We found this was a consistent theme throughout the home. We brought these concerns to the attention of the registered manager who acknowledged that there were large gaps in documentation. On the second day of the inspection, improvements had been made. Recording had improved and the absence of unpleasant odours had improved.

The registered manager was responsive to our concerns, however, failure to adequately assess people's continence needs and provide care and treatment in line with that assessed need is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's bedrooms were spacious, in good decorative order and had been personalised, for example with photographs, art and items of memorabilia. This helped to create a familiar, safe space for people. The registered manager told us, "We have recently refurbished and all bedrooms have recently been redecorated." People told us how they liked having their belongings and artefacts around them and having their own personal space.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. Throughout the inspection, we observed relatives coming and going and spending time with their loved ones in the lounge. One relative brought along their dog which people and staff enjoyed.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identify. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. Staff told us how they empowered people to make their own decisions on what they wished to wear. We spent time with one person in the lounge admiring their cardigan. They told us, "I do like my cardigans." On the first day of the inspection, a hair dresser was visiting the service. People told us how they enjoyed getting their hair done and staff spent the morning commenting on people's hair. One staff member commented, "(Person), your hair looks lovely, did you have a perm today?"

With pride and compassion, staff told us about the people they supported. One staff member told us, "I support one person, who is lovely. She knows what she wants and we help her with that. She's had a hard time recently and I've been supporting her with that. I can relate to how she feels and I hope I can change something in her life." Another staff member told us, "One person used to live in India, so we talk about that and their experiences there which they enjoy talking about." A third staff member told us, "I've worked here for over year eights and I love it. I've been asked by family members to support their loved ones to funerals over the years to provide support."

Throughout the inspection, we observed kind and gentle interactions between staff and people. Where people required one to one support with eating and drinking, staff sat down with the person, ensuring the person could hear them and eye contact was maintained. Laughter and appropriate humour was observed throughout many interactions and staff used kind tones when speaking with people, mirroring their body language to show they understood their requests.

Inadequate

Is the service responsive?

Our findings

The delivery of care was not person centred or consistently meaningful for people. The risk of social isolation had not been addressed and people spent their days with little or no interaction. One person told us, "I can only spend my days in bed no one keeps me company. Conversation is limited to them saying lift your leg please, roll over please, raise your arm please and then they are gone." Another person told us, "If I press my call bell they might come the same day. No one does any activities with me."

At our last inspection in January 2016, the provider was in breach of Regulation 9 and 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because complaints had not been dealt with in a timely manner and staff were not providing care that suited people's needs or reflected their preferences. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by June 2016. At this inspection, we found that the registered provider continued to breach this regulation.

Guidance produced by SCIE advises that it is important that older people in nursing homes have the opportunity to take part in activities, including activities of daily living that helps to maintain or improve their health and mental wellbeing. People should be encouraged to take an active role in choosing and defining activities that are meaningful to them. People had very little stimulation and the provision of activities was minimal. We received unanimous comments from people that the provision of activities was negligible. Comments included, "I have no activities." People were sitting in their armchairs for most of the day and there was a television on in the main lounge. However people did not appear to be watching this and either dozed or sat passively. The registered manager told us, "We did have an activity coordinator in post, however, they unfortunately left. We are actively recruiting." An activity board was on display which listed activities such as target games and tea and chats. However, we observed that these did not take place. On the second day of the inspection, target games were meant to take place in the morning. These did not take place. Staff members confirmed that constraints with staffing meant they were unable to provide meaningful activities. One staff member told us, "At present there is no one to do activities, only staff. However, we don't really have time for activities." Another staff member told us, "We don't have a lot of time for activities. It was nice when we had an activities coordinator." A visiting relative told us, " I have no complaint apart from the fact there is little to do but I understand they are recruiting; you'd think they would think of something in the meantime though, it doesn't take much to start a sing-along for example. I guess they are too busy to do that, they have so much to do."

Staff confirmed that within the current staffing levels, they did not have time to provide activities or one to one chats with people. One staff member told us, "At present there is no one to do activities, only staff. However, we don't really have time for activities." Another staff member told us, "We don't have a lot of time for activities. It was nice when we had an activities coordinator." This was echoed by people and their relatives. One person told us, "They don't have time to sit with me." We asked the registered manager how people's emotional, social and psychological needs were factored and considered when assessing and determining staffing levels. The registered manager told us, "We consider people's physical needs and of space course their social needs." We queried with the registered manager in the absence of an activities

coordinator what consideration was given to the staffing levels to ensure that people's emotional, social and psychological needs were met. The registered manager did not provide a definitive response but commented that, "In the summer staff supported people to go outside and they would be having a Christmas party."

There was a lack of stimulation and people were at heightened risk of social isolation. On the first day of the inspection, only six people spent the day in the lounge. Everyone else remained in their bedroom with their bedroom door closed. This meant people who remained in their bed, were unable to see and hear people coming or going or participate in the atmosphere of the home. We asked the registered manager the rationale for this. They did not provide a definitive response but advised it was due to fire safety and people's own preference to have their bedroom door closed. Throughout both days of the inspection, a large number of people spent all day in their bedroom in bed with the bed rails up with only the TV or radio for stimulation. One person told us, "No one sits with me." Another person told us, "There are no activities but I could do a puzzle if they had one." People's care plans failed to reflect whether this was people's individual preference to have their bedroom closed. The impact of the closed doors meant the risk of social isolation was heightened. Factors to mitigate and reduce the risk of social isolation had not been considered within people's care plans. People's social, emotional and psychological needs had been assessed as part of their pre-admission assessment; however, a subsequent care plan had not been formulated. People's social, emotional and psychological needs had been not been assessed and subsequently guidance was not in place to ensure the risk of social isolation was minimised and people's quality of care was enhanced.

Failure to provide meaningful activities and provision of care that suited people's needs or reflected their preferences is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People confirmed if they had any reason to complain they would raise their complaint with the manager or lead nurse. One person told us, "If I had a complaint I would tell (lead nurse)." No formal complaints had been received in over a year. At the last inspection in January 2016, the provider had not responded to complaints in a timely manner and the complaints policy failed to provide guidance to the complainant on the action to take if they were unhappy with the home's response to any complaint. An action plan was submitted which advised they would update and review their complaints policy and procedure by May 2016. During the inspection, we asked for a copy of the updated policy and procedure. The registered manager confirmed they had not updated the policy and procedure as noted in their action plan. Although the provider had not received any recent complaints, for future complainants information would not be readily available on the steps to take if they were unsatisfied with the home's response.

This is a continued breach of Regulation 16 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Systems were in place to involve people in the running of the service and obtain their feedback. Resident meetings were held on a regular basis and these provided people with the opportunity to discuss any concerns and give feedback. Minutes from the last meeting in October 2016 noted that people were asked individually if they had concerns. Comments included, "(Person) is happy with his care. He is happy with the housekeepers, he likes to laugh and joke with staff." Where people made specific suggestions, clear action points were documented. For example, one person had requested for salmon to be added to the menu whilst another had requested kebabs.

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at

enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. Care plans contained information on people's life history; however, consideration had not been given to people's likes, dislikes, and what was important to them. For example, if they preferred care from a female or male care worker; the time they preferred to get up and go to bed; their particular interests. From talking to staff it was clear they had spent time getting to know people and what was important to them. For example, one staff member told us about how one person's family was extremely important to them. However, the knowledge held by staff was not reflected in people's individual care plans.

We recommend that the provider seeks guidance from a national source on the implementation of person centred care plans.

People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. A care plan was then devised based on the pre-admission assessment. Care plans covered areas such as moving and handling, sleeping and eating and drinking. Information was available on the current problem, goal and support required. Care plans were reviewed on a monthly basis.

Inadequate

Is the service well-led?

Our findings

People had mixed views about how well Ashley Down Nursing Home was run. One person told us, "The manager is nice. I like everything about the care home apart from having to look after other people." A visiting relative told us, "The communication is good. If my loved one is not well they call me. They have taken her to the hospital twice. The manager is very nice." However, four people we spoke to were unaware who the registered manager was.

At our last inspection in January 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. This was because a robust governance framework was not in place and statutory notifications had not been made when people were deprived of their liberty. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by June 2016. At this inspection, we found that the registered provider continued to breach this regulation.

Systems for the monitoring and reviewing the quality of care, treatment and support provided were ineffective. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. Regular audits were being undertaken and these included care plans, medicines, staff training and supervision audits. However, these were not effective and had not identified the shortfalls in the delivery of care. For example, care plans were audited on a monthly basis by the home's administrator. The registered manager told us they completed these audits together but acknowledged his signature was not on the audit to confirm this. Care plan audits had failed to identify that care plans were not consistently fit for purpose or that further information was required. For example, moving and handling plans failed to record the size of the sling required and the loop attachments needed. Staff demonstrated a sound understanding of people's individual sling sizes and confirmed that people had their own individual sling. However, for new members of staff or agency staff this information was not readily available. The care plan audit had also failed to identify that communication care plans were not in place. For example, one person living with advanced dementia had limited verbal communication skills. Guidance was not available on how best to communicate with this person. A social well-being care plan dated 3 May 2015 noted 'activity coordinator provides one to one activities.' This care plan had been updated monthly recording 'no change, care plan still effective.' However, the home did not have an activity coordinator in post.

The risk of people developing pressure ulcers had been assessed using the Waterlow Score (nationally recognised tool to assess people's risk of skin breakdown) and these were reviewed monthly. However, we identified three people's Waterlow scores which had been calculated incorrectly. We brought these concerns to the attention of the lead nurse where we calculated the Waterlow Score together and they recognised the error. Despite the Waterlow Score being calculated incorrectly, action had been taken to minimise the risk of skin breakdown, such as application of barrier creams and regular repositioning. However, the provider's internal care plan audit had failed to identify this shortfall. A training audit dated 7 October 2016 noted that a review of all 'residents' medical needs had been undertaken in the last six months to ensure that no additional training was needed. The audit noted 'yes and all clinical care plans are

reviewed monthly. Training would be backed accordingly.' The audit failed to identify that nursing staff and care staff had not received training in epilepsy, diabetes and pressure care.

Incidents and accidents were audited on a monthly basis for any emerging trends, themes or patterns. The latest audit for October 2016 did not identify any emerging themes. However, documentation failed to record what action was taken following each individual incident and/or accident. For example in September 2016 one person informed a staff member that money was missing from their wallet. The registered manager told us, "I looked into this and spoke with the person and their relative and it was felt they did not have this money in their wallet." However, this investigation was not recorded, there was no evidence or any learning or actions taken to ensure further incidences of this were mitigated. The registered manager confirmed they had not recorded the outcome of their investigation.

Systems were in place to obtain feedback from relatives and staff. However, the provider was unable to demonstrate how they used this information to drive improvement and demonstrate the changes they had made. For example, satisfaction surveys had been sent out to people and their relatives in January 2016. Feedback was positive which comments such as 'Superb home, very happy my Mother is here.' However, where people had identified they were dissatisfied with the service, the provider was unable to demonstrate what action had been taken, how the feedback was analysed, reported to people and used to make improvements. The registered manager told us, "Following the satisfaction survey, we make improvements and I am continually making improvements, but I acknowledge these are not documented." A staff meeting held in October 2016 identified concerns about care staff refusing to help other care staff as the 'resident' was not on their list or ignoring people and staff speaking in their own language in front of people. We asked the registered manager what action had been taken to address these concerns. They told us, "We are working on this every day." We queried if an action plan was in place to demonstrate what actions or changes had been implemented to address these concerns. The registered manager confirmed they had not formally documented an action plan.

Robust systems were not in place to govern the service and provide guidance for staff. During the inspection we asked to see the provider's policies and procedures. The registered manager provided two folders. One folder contained a wide range of policies and procedures which dated back to 2000. They referenced the Care Standards Act 2000 and did not reflect up to date policy and legislation. The second folder, contained policies and procedures which related to health and safety. We asked to see the provider's current policies and procedures which related to the running of the service. For examples, policies around safeguarding, diabetes, end of life care, MCA 2005 and pressure care. The registered manager told us, "We are in the process of getting a new governance system and they will provide us with policies and procedures." In the interim, relevant and up to date policies and procedures governing the running of the home were not available or accessible to staff.

The provider had not maintained service improvement plans to demonstrate how they monitored progress against plans to improve the safety and quality of the service. We queried with the registered manager how they could demonstrate what improvements were being made. They told us, "We are continually improving the environment. I have refurbished the whole home, ordered new chairs, new flooring, new beds and a new microwave." However, the registered manager confirmed these improvements were not documented in a service improvement plan. From our observations it was a clear that significant improvements had been made to the décor of the home. However, in relation to the breaches of regulation identified at the last inspection in January 2016, the provider had failed to implement an action plan to demonstrate how improvements were/if being made.

Over the past years, inspections of this service have found several breaches of the 2010 and 2014 regulations

since 2013. We found the same or similar breeches in regulations were the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This was a continued breach of Regulation 17 the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection in January 2016, the provider was in breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009. This was because a robust governance framework was not in place and statutory notifications had not been made when people were deprived of their liberty. At this inspection, we found that the registered provider continued to breach this regulation. The provider had failed to notify us when the outcome of DoLS applications had been granted. Since that inspection, the provider has still not notified us. We queried with the registered manager whether they had made these notifications which they confirmed they had not.

This failure to notify the CQC was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff commented that they enjoyed working at Ashley Down Nursing Home. One staff member told us, "We are one big family here." Another staff member told us, "There is a good bunch of staff here." Another staff member told us, "Everything is going well." Staff confirmed they felt able to approach the manager or lead nurse with any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of important incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to fully evidence and demonstrate that the frequency of checks was based on the person's individual assessed needs. Regulation 9 (1) (2) (a) (b) (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and had provided care and treatment of service users without the consent of the relevant person. Regulation 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to act on complaints received. Regulation 16 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and Treatment was not provided in a safe way for service users. The provider had not assessed the risks to the health and safety of service users of receiving the care or treatment and they had not done all that was reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (a) (b).

The enforcement action we took:

Warning notices have been served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established systems and processes to effectively to ensure compliance with the requirements in this Part. They had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided had not been maintained. Regulation 17 (1) (2) (a) (b) (c).

The enforcement action we took:

Warning notices have been served.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of this Part. Regulation 18 (1).

The enforcement action we took:

Warning notices have been served.