ZMA Manchester Limited

Ashley House Residential Home

Inspection report

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Date of inspection visit:
25 September 2017

Date of publication:
27 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The service was last inspected in December 2014 when it was found to be meeting all the regulatory requirements, and the service was rated 'Good' overall.

Ashley House Residential Home (known as 'Ashley House' by the people who live and work there) is registered to provide accommodation and personal care for up to 18 people, some of whom are living with dementia, there were 17 people living at the home at the time of our inspection. The home is situated on the main road close to local amenities and public transport links into Manchester city centre, Didsbury and Chorlton. The home is a large detached property set in its own grounds. Car parking is available on the road. There is a lounge and a separate dining room on the ground floor. There is a passenger lift in place along with facilities for cooking, dining, personal care, relaxing and leisure.

During this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to management of medicines, risk assessments, person centred care, meeting people's social needs and quality assurance. You can see what action we told the registered provider to take at the back of the full version of the report.

There was a registered manager in post. 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.

We found people were not always protected from risks associated with their care because risk assessments were not always robust enough to provide guidance and direction to staff about how to keep people safe. People did not always have sufficient detail in their care plans to provide guidance and direction to staff about how to meet their needs.

People's medicines were not managed safely. For example, we observed one care worker not safely observing the person taking their medicines they had just administered. We found the storage of controlled drugs did not meet the requirements of the Misuse of Drugs Act 1971. We found there were no plans, or 'when required' (PRN) protocols in place to inform staff when and how they should administer people medicines that were not required routinely.

During our tour of the building we noted several potential safety hazards. We found in the first floor bathroom had two radiator covers stored behind the bath tub. Both radiator covers had sharp edges and we requested that they were removed immediately. We found items of clothing and an inflatable mattress were being stored under the stairwell, this posed as a potential fire risk.

Overall people and relatives spoken with were positive and complimentary about the service they received at the home. People told us that they felt safe and were cared for.

During this inspection we found there were enough staff available to meet the needs of people living at the home. However, staff didn't have time to provide social interaction with people and we noted the care hours during the weekend were reduced by one 8am to 2pm shift. We have made a recommendation the home considers introducing a dependency tool which will provide further clarification on whether the current staffing levels are adequate.

Activities on offer to people were limited. We received a negative response from people in relation to activities. The range of activities available was not always appropriate or stimulating for people. This meant people were not always protected from social isolation.

We saw caring interactions between staff and people. However, we observed one care worker not engaging with a person in a caring and sensitive manner which meant the person's dignity was not respected.

The home was generally clean and tidy, although we found a malodour in communal areas. The registered manager suggested the carpets were planned to be replaced, but no clear timescale of this work had been agreed.

Staff had received appropriate training, supervision, and appraisals to support them in their roles. Staff, with the support of the management team identified their professional needs and development and took action to achieve them. However, we have made a recommendation because it was not clear how new staff were supported through the care certificate. This meant we could not be fully assured new staff had received a robust induction in health and social care.

We noted the home had two fire risk assessments in place dated December 2016 and September 2014 which had been completed by two external fire safety companies. The registered manager informed us the fire risk assessment in December 2016 was deemed not to be sufficient by Manchester Fire and Rescue Service in March 2017, and they suggested the home uses the fire risk assessment from March 2014. We noted there was no clear documentation stating this. We have made a recommendation the provider undertakes a new fire risk assessment ensuring this replaces the any outstanding fire risk assessments to avoid confusion.

We found the service was working within the principles of the Mental Capacity Act (2005) (MCA). Best interest meetings and capacity assessments were held where required. Applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made. However, we found staff understanding of the MCA 2005 and DoLS was limited as no training had been provided. We noted some consent forms had not been completed correctly.

A process was in place for managing complaints and the home's complaints procedure was displayed so that people had access to this information. People and relatives told us they would raise any concerns with the manager.

Audits on the home's quality were not accurate which meant systems to improve the quality of provision at the home were not always effective. We found the home in breach of the regulation in relation to good governance as there were not effective systems in place to monitor the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always being managed safely. For example, we observed the senior care worker handing medication to people, but not observing the person to ensure they had taken their medicines safely.

People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks.

There were sufficient staff to meet people's daily needs. However staff did not have time to also arrange regular activities for people to be involved with.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff we spoke with had little knowledge regarding MCA and DoLS, this was due to no MCA and DoLS training being made available.

The home was in need of maintenance work and re-decoration. Some work had been completed and but we noted no plans had been devised to provide clear timescales.

Throughout the home there was little evidence of any attempts to create a dementia friendly environment.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff treated people in a kind and compassionate manner this was not always demonstrated by others.

People's care was not always planned and provided in a personalised, respectful manner.

The home was in the process of training senior staff to support

people and colleagues at the end of people's lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were insufficient to safely meet people's needs as they did not always identify and manage risks to people's health and well-being.

We saw few activities taking place during the inspection. There was no structured plan in place to ensure people were socially stimulated.

The service had systems in place to record and investigate any complaints they received.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised.

A registered manager was in place as required by the service's registration with the CQC.

Staff told us they enjoyed working in the service and found the manager to be both approachable and supportive.

Ashley House Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 25 September 2017 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had personal experience of services for people living with dementia.

Before the inspection we reviewed the information we held about the service. This included seeking feedback from Manchester local authority and Manchester Healthwatch. Feedback from the local authority was positive with no concerns highlighted.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Manchester Heathwatch didn't have any intelligence on this service at that time.

Before the inspection we 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. We reviewed the completed PIR and we checked information that we held about the service and the service provider. This included information from other agencies 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 provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spent time observing care in the communal lounge/dining rooms and used the Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

During the inspection we spoke with 10 people who used the service, one person's relative, the owner, the registered and deputy manager, one senior care worker and two care workers.

We looked around the building. This included going in people's bedrooms (with their permission), bathrooms, medicines store room and in communal areas. We inspected records, which included three people's care records, medicine administration charts, three staff recruitment files, the staff training matrix, staff supervision records and other documentation relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. We asked four people who lived at the home if they felt safe and they told us they did. Comments we received included: "Yes I feel safe", "Yes I think so", "I have my frame that keeps me upright, I feel safe" and "I believe it is safe here." One person's relative commented: "My Mum is very comfortable here; I think she is safe here. Staff are busy, but always milling around."

We looked at three care files for people who were living at Ashley House. The provider had generic risk assessments in place for people using the service, but detailed risk assessments for specific issues such as pressure ulcers were not in place. The generic risk assessment document covered the following: personal care, dressing, vision/hearing, continence, eating and drinking, pressure sore care, social and recreational, moods, pain and sleep, and bed rails. We noted from one person's care plan they were at a 'very high' risk of pressure areas and were being treated for a water lesion. A skin lesion is a part of the skin that has an abnormal growth or appearance compared to the skin around it. We found no evidence a specific pressure area management plan to provide clear guidance to care staff and how to reduce any identified risks. We discussed this area with the care workers on duty who confirmed that regular repositioning was happening, however we found there was no written documentation to support this. The registered manager and staff confirmed that they received support from the district nursing team for people with concern around pressure areas and they were able to access equipment via the nurses to reduce the risk of pressure concerns occurring, but acknowledged this person's risk assessment and care plan for pressure ulcer care needed to be developed.

Other risk assessments we viewed were vague and lacked person centred information on the actions required to minimise and control actual or potential risks. This had the potential to place the health and welfare of people using the service at risk. We found many of the risk assessments were pre-populated. For example we found many of the evaluations did not clearly provide an update to the actual assessments as it was not clear what section of the care plan the evaluations were referring to. Therefore it was difficult to determine whether or not the risk assessments had been updated when people's needs had changed.

People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks. This is a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the building we noted several potential safety hazards. We found in the first floor bathroom two radiators covers had been stored behind the bath tub. We noted both radiator covers had sharp edges and we requested that they were removed immediately. During our tour of the home we found items of clothing and an inflatable mattress was being stored under the stairwell. This storage in a stairwell contributes to combustible material load. In a fire, people would use the stairs and not the passenger lift. Therefore, stairwells must not have combustible material stored due to the risk of a fire starting from the stairwell and resulting in the collapse of the stairwell. During the day of the inspection we noted these items were removed.

We viewed the secure garden area of the home and noted a concrete ramp had been installed to assist people with mobility restrictions. We noted there was approximately a 3cm gap between the ramp and floor, which presented as a tripping hazard. We discussed this with the registered manager who assured us this would be passed on to the owners of the home. During the tour of the home we noted a number of walls throughout had superficial cracks, although this didn't compromise the safety of the people we found this work needed addressing. We noted from one person's bedroom there had been a leak. During the inspection we observed the maintenance person attempting to fix this problem. We were informed by the registered manager this leak appeared two weeks ago and had been fixed, but again it had returned. We found this didn't compromise the safety of the people in the bedroom. During our tour of the home we could see a number of people's bedrooms had be refurbished, but we noted there were still some bedrooms which didn't have PVC windows, and we found evidence in one person's bedroom where the wooden window frames had started to rot. We found these windows did have restrictors fitted to prevent people from climbing through them and falling from height. We discussed this area with the owner of the home who visited during the inspection, we were reassured this work had been highlighted as part of the homes refurbishment plan. We asked to view this refurbishment plan, but this wasn't available when we asked the registered manager.

The above shortfalls in managing the home safely is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for some of the medicines with others supplied in boxes or bottles. The medicines were stored in a trolley in a small lockable room within the home. We looked at eight people's medicine administration records (MAR). We also reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and people had received the medication they had been prescribed. We found people's medicines were available at the home to be administered when they needed them.

We noted refrigerated medicines were stored in the homes kitchen in an unlocked domestic fridge in a sealed plastic container. We found this fridge was also used to store staff food. We noted the home had completed daily temperature recordings. Dedicated medicines fridges should be of a suitable standard to ensure medicines are kept at the correct temperature. However, in exceptional circumstances, smaller care homes which do not regularly have medicines which require refrigeration, might consider using a separate, sealed and locked container in the food fridge. Access must be controlled appropriately and temperature records kept. However, on this occasion we found the storage of people's refrigerated medicines had not been risk assessed by the provider to ensure the current storage was safe.

Controlled drugs are certain medicines that due to their risks of misuse or abuse, are subject to more stringent legal requirements in relation to their storage, admiration and destruction. We saw controlled drugs were stored in a separate safe, which had not been bolted to the wall as required.
Controlled drugs cupboards must meet British Standard BS2881:1989 security level 1. The Safe Custody Regulations specify the quality, construction, method of fixing and lock and key for the cupboard. The controlled drugs cupboard must be: secured to a wall and fixed with bolts that are not accessible from outside the cupboard, fitted with a robust multiple point lock (or be a digital code), made of metal with strong hinges and the walls of the room should be of a suitable thickness and made of a suitable material e.g. bricks, so that the cupboard is fixed securely. This meant the homes current storage of controlled drugs did not meet the requirements of the Misuse of Drugs Act 1971.

We saw all controlled drugs had been signed by two staff when administered or booked in, and a spot check

of stocks did not find any discrepancies. We saw photographs of the people using the service had been attached to medication administration records to help staff correctly identify people who required medication and reduces the risk to people accidently being given medication that is not prescribed to them.

We found there were no plans, or 'when required' (PRN) protocols in place to inform staff when and how they should administer people medicines that were not required routinely. Whilst staff we spoke with understood what people's medicines were required for, this would increase the risk that people would not receive medicines as they needed them consistently.

We observed some people being given their medicines at lunchtime. We noted the senior's care workers approach did not follow good practice in relation to safe administration. For example, we observed the senior care worker handing medication to people, but not observing the person to ensure they had taken their medicines safely. We noted this happened on two occasions. We passed on these observations to registered and deputy managers. This meant we could not be assured people safely received their medicines as prescribed.

During the tour of the home we found in one person's bedroom they had pain relief gel that should have been stored in in the medicines clinic room. This cream had the person's name printed on it, which had smudged and not clearly legible. This meant the expiry date was not clear. This pain relief gel was immediately removed by the senior care worker who said the gel should have been returned to the pharmacy because they have another gel already in use. This meant person's pain relief gel had not been safely stored and potentially meant this gel could have inappropriately been applied by the person.

We found that some creams were stored in peoples own bedrooms. The registered manager informed us this was because they were required at the point of care delivery or some people used these independently. There were no assessments carried out to ensure that people were able to manage these correctly. Furthermore, no consideration given to the potential risks of others access to these medicines whilst they were not stored securely.

These shortfalls in the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home was clean and tidy. The home had employed a housekeeper who worked 16 hours a week. This included communal areas, in people's rooms, in bathrooms and toilets and the equipment people used. However, there was a malodour in the hallway and communal living parts of the home. We noted the carpets in place were clean, but would benefit from being replaced to ensure the malodour was addressed.

We saw that the local authority NHS Trust's infection control team had completed an audit in December 2016 and the service had been rated 64% compliant overall. We noted the previous audit score rated the home at 83%, therefore the home's compliance of infection control has dropped meaning the service went from a green to amber RAG rating. We noted an area from this audit was the installation of sluice facilities. Speaking to the registered manager they were not clear when this work would take place.

We found a policy and procedures were in place for infection control. Training records showed that 11 out of the 14 members of staff were provided with training in infection control. We saw monthly infection control audits were undertaken, which showed any issues were identified and acted upon. However, the home had not yet addressed the installation of sluice facilities to minimise risks of cross contamination.

People living at the home told us they felt there were sufficient staff on duty to meet their needs, but some people felt staff were busy in the mornings which meant they had to wait if they needed assistance with toileting. Comments from people included, "There seems to enough staff on", "I have to wait sometimes in a morning", "They could do with more staff. Staff are very busy, so I do wait" and "I think we have enough staff on."

The staff we spoke to felt there were enough staff on duty in the week, but commented that weekends could sometimes be problematic as the a cook wasn't always available, which meant care staff were responsible for cooking meals. The registered manager said they were looking at recruiting a weekend cook.

We viewed the rotas for the month of August 2017. We noted during the week the staffing levels were one senior care worker and two care workers from 8am to 8pm. We noted this also included one care worker on duty from 8am to 2pm to assist. There was also a cook who was on rota to work seven days a week from 10am to 3pm. The registered and deputy manager's hours were supernumerary to these and tended to be between 8am to 5pm during the weekdays.

During the weekends we noted the staffing levels were reduced. This was one senior care worker and two care workers from 8am to 8pm. This meant the morning 8am to 2pm shift was not in place on weekends. We discussed the rationale for this with the registered manager who said the weekends were much quieter as the office phone didn't ring as much. Although this may be the case we found the weekend shouldn't make a difference to the weekdays as people's personal care needs were still the same and meant people may have been waiting longer for their care. The registered manager acknowledged this observation and said they would review further with the owner. We noted that a staffing dependency tool to calculate staffing hours and people using the service had not been devised. We recommend the home considers introducing a dependency tool, which will provide further clarification on whether the current staffing levels are adequate.

During the inspection, we observed there were care staff located in or close to communal areas, and people received support promptly when they required it.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse to the registered manager. Care workers could explain the forms of abuse that the people using the service could be vulnerable to. All care workers we spoke with said that they would report any concerns to the registered manager. We viewed the homes training matrix and found two of the 14 staff were due to complete safeguarding training. The registered manager was aware these staff members needed to complete this training and was in the process of ensuring they attended this course. Referral procedures for safeguarding concerns were clearly displayed in the house foyer. This meant that staff understood their responsibilities in terms of safeguarding and people were kept safe.

We looked at three newly recruited staff personnel files to check how the service recruited staff. We found that a safe system of recruitment was in place. The files contained the following; application forms that documented a full employment history, a medical questionnaire, a job description and two references connected to the applicants previous employment. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We found people had personal emergency evacuation plans (PEEPs) in place to help protect them in the event of an emergency. These plans detailed if a person was independently mobile or what support they would require to evacuate the building during the day and at night. This meant information was available for the emergency services in the event of the building needing to be evacuated.

We looked at the records for gas and electrical safety and manual handling equipment checks. All the necessary inspections and checks were up to date. We noted the home had two fire risk assessments in place dated December 2016 and September 2014 which had been completed by two external fire safety companies. The registered manager informed us the fire risk assessment in December 2016 was deemed not to be satisfactory by Manchester Fire and Rescue Service in March 2017, and the provider was advised by the fire safety officer the fire risk assessment from March 2014 was much more robust than the one completed in 2016. We noted there was no clear documentation stating this. We have contacted Greater Manchester Fire and Rescue Service for further clarification from their visit.

We recommend the home undertakes a new fire risk assessment ensuring this replaces any outstanding fire risk assessments to avoid confusion to ensure the fire risk assessment is robust in the event of an emergency.

We found regular checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. This included fire safety systems, call bells, water temperatures and electrical equipment. Gas, water and other appliances were also regularly serviced. Risk assessments were in place for the premises, environment and use of equipment to ensure risks were kept to a minimum. Staff had access to personal protective equipment such as aprons and gloves and they used these as needed. We noted fire drills had regularly been undertaken by the home for day staff, but none had been recorded for night staff. The registered manager agreed this would be completed going forward.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the staff working at the home. Comments from people included: "I make my own decisions, I choose when I get up and go to bed", "I decide pretty much what I want yes" and "The carers know my needs so I am happy."

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 be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager maintained a record of people subject to a DoLS.

The registered manager had made applications to the supervisory body where they had identified this was required. The registered manager didn't have a tracking sheet to monitor when applications had been made, whether there were any conditions on the authorisation, and when the authorisations expired. During the inspection the registered manager set up a matrix to help her keep a clear overview of people's authorisations.

The staff we spoke with had little knowledge regarding MCA and DoLS, this was due to no MCA and DoLS training being made available. However, they demonstrated that they understood the importance of consent, offering choice, and helping people to make decisions. During our inspection we witnessed this in practice as we saw staff checked people's consent to the care they were providing.

In most cases, where it was considered that people lacked capacity to consent, consent forms were included in the care plans in relation to photographs, medication and being weighed. These were signed by a member of the person's family. However, it wasn't clear if the family member's signing the forms had legal authority to provide consent on their family member's behalf, such as a Lasting Power of Attorney (LPA) for health and wellbeing. We found the home used consent forms in an inconsistent manner. One person, who was considered to have capacity to consent, had not signed consent forms for their care and treatment. This person's photograph was in their file and on the medication file. But there was no form present on this file relating to consent to the use of their photograph.

Under the MCA a relative cannot give consent on behalf of a person who lacks capacity to consent themselves. The only exception is if the relative or a representative has been granted a LPA for health and wellbeing. In the absence of that, there must be a best interest's decision. The MCA Code of Practice gives advice about how to reach such a decision. Depending on the situation, it does not have to be too formal.

We discussed this issue with the registered manager who confirmed they would be reviewing all consent forms in people's care plans as they accept they misunderstood the requirements of the MCA.
We recommend the provider ensure MCA and DoLS training is arranged for all care and management staff.

We examined further training records which demonstrated that regular training was provided. The registered manager maintained a spread sheet record of staff training and recorded when staff had completed training sessions. This allowed the registered manager to monitor the training and to check when it needed to be updated. We saw that staff had received training provided by external organisations in areas such as, manual handling, first aid, fire safety. Medication training was undertaken annually. We noted during the inspection from one person's care plan their pressure ulcer care was not clearly recorded how staff were meant to manage this. We noted staff were not provided training in this area and relied on the advice they received from visiting community nurses.

We recommend the provider ensures pressure ulcer management training is provided to all care staff to ensure they can safely manage people's needs.

We noted the provider's three day induction did not cover the standards set out in the Care Certificate. The certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. We discussed this area with the registered manager who confirmed she would be discussing this with the owner to look at how they can provide this induction to new staff.

We recommend the provider ensure the Care Certificate is implemented to new and existing staff who have not previously completed an induction.

Staff had regular supervision and appraisals. Staff confirmed that they had the opportunity to meet with the registered manager on a regular basis. We saw from the records that the registered manager had a matrix in place to ensure that supervisions were undertaken regularly.

We asked people what they thought of the food at Ashley House and the feedback was generally positive. Comments included, "The food is good, you can have seconds", "There is plenty", "The food suits me, it's plain but ok" and "We are asked daily what we want."

We observed the lunchtime meal during our inspection in the dining room. Dining tables were set with place mats and cutlery and condiments were provided to people when the meal was due to be served. Most people ate in the dining room at lunchtime but people told us that they could eat in the privacy of their room should they choose.

The dining tables were laid with place mats and napkins. Condiments were not placed on the table until they were asked for. Knives and forks were placed on the table after meals had been put down. People received juice and we noted that no other option was given. We observed people were offered additional portions after they finished their meal. However, we found the level of interaction between staff and the people were inconsistent. For example, we observed one staff member speaking to people and asking did they require assistance, while other staff entered the room on occasions and provided little interactions with people. We noted the home had not previously completed any dining room experience audits. We recommend the provider's reviews the meal time experience for people.

The most recent local authority food hygiene inspection was in August 2016 and Ashley House had been awarded a rating of 5 stars. The highest award that can be given is 5 stars.

We found some areas of the décor around the home appeared tired; the paintwork was scuffed and the flooring in some areas was contributing to the malodour around the home. The walls and communal areas upstairs were bare.

Throughout the home there was little evidence of any attempts to create a dementia friendly environment. For example, there was no pictorial or directional signage, use of contrasting colours on grab rails, and no use of memory boxes, photos or other ways to help people identify their rooms. Such adaptations would support people to remain independent for as long as possible. There were heavily patterned floor coverings throughout the home, which can cause potential confusion to some people with visual impairments or who are living with dementia.

We recommend the provider reviews good practice guidance on developing dementia friendly environments and considers alterations to the environment in consultation with people living at the home.

People told us they could see a GP if they needed to and their relatives agreed. Records were kept of food and fluid intake levels when people were at risk nutritionally and we found that they were completed consistently. People were weighed monthly and appropriate action was taken if people lost weight, for example a referral to the dietician or an appointment with a GP.

Requires Improvement

Is the service caring?

Our findings

We asked people if they thought the care staff were caring and the feedback was positive. People told us: "Staff are lovely yes", "Very kind to me", "[Staff] always very nice with me", " [Staff] look after me yes", "They [staff] are helpful", "I feel treated properly" and "They do their best." One person's relative commented: "Mum is well cared for here. I can see this when I come to visit. Mum would also tell me if this was not the case. She always looks clean and well dressed."

During the inspection we saw staff were kind and caring when interacting with people who lived at the home. We observed one person became distressed and a staff member sat with them, holding their hand and speaking quietly to reassure them. We saw that during this the person's dignity was protected. The staff member asked if the person would prefer to move to a quiet area and on refusal, the care staff respected their wishes and sat in front of them so they could not be observed by other people in the area.

However, during the inspection we found some caring interactions differed. We observed a lunch time meal being served to one person who said they didn't want the meal because they asked for something else. We observed a member raising their voice and stating this is the meal you asked for. The care worker did not communicate this in a sensitive and caring manner. The care worker didn't consider the person may have forgotten or that they were entitled to change their mind. Shortly after this observation the care worker did provide a different meal and commented 'are you happy now' in a raised voice. This did not promote the dignity of the individual involved.

During the afternoon of our inspection we sat in the lounge and observed six people sleeping with blankets over their knees. One person we spoke to said they felt cold and wanted to go to bed. We noted the heating in the lounge was not switched on. We discussed this further with one of the care workers who immediately switched the heating on in the lounge. We questioned why people needed blankets in the lounge and we were informed people sometime felt the lounge was cold at times. We noted the provider completed daily room temperature recordings and could see the average temperature recorded was 21.5c.

We recommend the registered provider reviews the temperature in communal areas to ensure this accommodates people's preferences.
We saw in two of the three care files we looked at detailed information about a person's background. Likes and dislikes were recorded and a one page profile was at the front of the file for easy access of the information. The third file did not have the one page profile in place; their likes and dislikes were contained within the file and so not as easily accessible.

We saw that people's bedrooms had been personalised with their own furnishings, ornaments and pictures; they were also clean and tidy. This showed us that people were encouraged to individualise their rooms and that care workers respected people's belongings.

During the inspection we noted nobody living at the home was receiving end of life care. We asked if there was a specific approach or model of end of life care that the home would provide should anyone be

approaching the end of their life. The registered manager provided evidence that the staff were currently undertaking the 'Six Steps' end of life programme. The aim of the 'Six Steps' end of life programme to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care.

People's wishes for their end of life care were recorded. For example, some people had a do not attempt resuscitation (DNAR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw that the person concerned and their family were involved in this decision. Care workers were able to tell us how they supported people, families and colleagues when a person passes away and the home had a memorial tree situated in the garden which displayed photos of people who had passed away at the home.

There were a number of thank you cards and compliments about the service available to read. Some of these were very complimentary about the care that people had received. One comment included, "Thank you for the incomparable care and care given to [person's name] during his time at Ashley House. This made his last few years very happy and gave his family peace of mind knowing that he was getting exceptional care."

None of the people receiving personal care services at the time of our visit had particular needs or preferences arising from their religious or cultural background. The provider's assessment process would identify these needs if necessary.

Requires Improvement

Is the service responsive?

Our findings

We found care files did not correctly capture people's assessed needs. We noted from the care files viewed there were no pre-admission assessments available on file. Staff told us that they were made aware of the needs of people moving into the home and would read social worker's documentation about the person's needs. Pre-admission assessments are an essential part of planning and assessment, to ensure a care plan is created to clearly meet the person's health and social care needs and to demonstrate the provider had considered whether they could meet the person's needs prior to them moving in.

Care plans were basic and generic, although they were reviewed and evaluated on a monthly basis to check if any change was needed. This evaluation did not always highlight if people's circumstance had changed. This meant that the level of support required by people was not assessed and documented so that care staff would understand how to meet people's needs.

For example, one person had been seen regularly by the district nurse to have their pressure area monitored. This person's care plan did not record any issues concerning this person's skin care or the input from the district nurses. Due to the minimal information in the care plan we discussed this matter with the registered manager, who was able to provide additional information for the reasoning why the district nurse had been visiting this person. However, the care plan did not provide this valuable information.

People's preferences in relation to their care, support with personal care and food preferences had been recorded. However we saw there were inconsistencies with the care plan not covering people's essential needs. For example, we found no care plans that included personalised details of the support people required for aspects such as living with dementia, diabetes and epilepsy. This meant that the correct level of support required by people was not assessed and documented so that care staff would understand how to meet their needs.

This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

People we spoke with told us that activity choices within the home were limited. Comments included: "I don't go out a lot, I would like to", "There isn't much going on", "If you like throwing a ball back and to, that's what there is", "I don't know why we can't go out more", "There is nothing to do", "People sleep a lot", "There are no activities" and "The home is too cold to get up to do anything."

People's social needs were not being met. During the inspection we did not observe any pre-arranged activities for people taking place. We observed only two activities taking place involving a care worker throwing a balloon to a couple of people and one care worker playing a game of cards with one person. We noted that there was no activities information on display to notify people about the week's forthcoming activities. We found no other activities in place to stimulate people and staff were busily engaged in care tasks and had little time to positively interact with people.

We spoke to the registered and deputy managers who said the care assistants organise the activities, and they always ask the residents what they like to do on a daily basis. They said the home does try and arrange trips out in the community and recently people went out for a meal and tea dance. The managers confirmed the home does attempt to raise money to help with these activities. Comments from staff on activities included: "I have brought up activities with the manager, the residents don't often go out and they want to, we try and do what we can" and "We don't have an activities coordinator, we try and do dances and put a film on when the residents want it."

We observed people little interaction and stimulation throughout the day and found no evidence to assure us people's social needs were met. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's social needs were not being met.

We saw there was an up to date complaints policy that contained details of organisations external to the provider that people could contact if they were not satisfied with the handling of their complaint. People we spoke with told us they would feel confident to raise a complaint should they feel this was necessary. We looked at the provider's record of complaints and we saw complaints had been investigated, and actions taken to resolve complaints.

Requires Improvement

Is the service well-led?

Our findings

We asked people who used the service whether they found the service provided at Ashley House to be well led. People spoken with confirmed they were happy with the way the service was managed. Comments from people included: "I know the manager, its [registered manager's name]", "She [registered manager] is good", "She [registered manager] listens" and "She [registered manager] is very approachable."

The provider employed a registered manager on a full time basis who was supported by a deputy manager and her staff.

All the staff we spoke with were supportive of the registered manager. They told us; "If there are concerns, if something needs replacing, they will sort it" and "The manager does her best, I feel supported."

During the last inspection in December 2014 we saw improvements had been made and there were sufficient quality assurance audits in place to ensure any shortfalls were identified. At this inspection we found a number of shortfalls and found the audits in place for medicines, health and safety, and care planning were not robust enough and hadn't identified the shortfalls we. Audits were undertaken for aspects of care such as medicines, care plans, infection control, and people's weights. We noted the registered manager produced an annual care statement, which analysed aspects of care such as weight concerns, pressure sores, dietary needs, safeguarding, health checks, care plans, medication errors, hospital admissions and deaths. Although this summary provided a useful overview of the home it didn't highlight or suggest any of the shortfalls found during this inspection.

Furthermore we noted areas within the home that needed improving such as the replacement of carpets and windows had not been recorded in an improvement plan to assure us this work had been planned with clear timescales.

It was evident that there were gaps in the quality assurance systems and significant scope for improvement. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider has not ensured effective systems were in place to monitor and improve the quality of service provided.

There was a system in place to monitor accidents, incidents or safeguarding concerns within the home. The registered manager maintained a monthly record about the incidents that had occurred and what had been done in response. Additionally, there was a record of what the outcome was and any 'lessons learned' to help prevent future re-occurrences.

People had an opportunity to attend residents meetings. The registered manager told us residents meetings took place at least twice a year. The meetings discussed various subjects that included the quality of food, care and the service. The most recent meeting took place in February 2017 and it was recorded that people were happy the bathroom had been upgraded as people could have more baths at night. In addition, the service obtained feedback from people who used the service and relatives to identify areas that needed

improvement and to assess the impact of the service on the people using it.

We noted team meetings had been coordinated for staff to attend once a year. We discussed with the registered manager the benefit on increasing these meetings to ensure staff are fully aware of changes within the homes and changes to legislation.

Our records demonstrated that the registered manager notified CQC of significant events appropriately, as legally required to do so.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were insufficient to safely meet people's needs as they did not always identify and manage risks to people's health and well-being. And We saw few activities taking place during the inspection. There was no structured plan in place to ensure people were socially stimulated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate the risks. And During our tour of the building we noted several potential safety hazards that had not been identified by the provider. And Medicines were not always being managed safely.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The quality and safety monitoring of the service was ineffective at identifying where the quality and the safety of the service was being compromised.