Clearwater Care (Hackney) Limited

Ash Lea House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 30 November 2016. The inspection was unannounced. Ash Lea House provides accommodation for up to 14 people with a learning disability. It is located in Alfreton, Derbyshire. On the day of our inspection 13 people were using the service.

The service had a registered manager in place at the time of our inspection. 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.

People may not be supported in the safest way by staff because possible concerns to their safety were not reported to ensure people were protected from avoidable harm. Risks in relation to people's daily life were not always assessed so plans could be made to protect them from harm.

People were not always supported by enough staff to ensure they received care and support when they needed it.

Medicines were managed safely and people received their medicines as prescribed.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to make decisions and staff knew how to act if people did not have the capacity to make decisions for themselves. People were not subjected to any restraint or unlawful restriction.

People did not receive the support they needed to monitor and ensure their healthcare needs were met. They were provided with support to maintain sufficient nutritional intake.

People lived in a service where staff listened to them. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting. People were supported to enjoy a social life.

People's care and support was not planned in a clear way that took into account all their needs and aspirations. People had opportunities to participate in social and community based activities, although plans made were not always followed through. People were confident that any concerns or complaints would be listened to and acted upon.

People who used the service, relatives and staff had opportunities to give their views on how the service was run. Systems followed to monitor and improve the quality of the service provided did not identify all of the areas where improvements were required.

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 entirely safe.

People were placed at risk of abuse and harm because the provider did not have effective systems in place to recognise and respond to allegations or incidents.

There were times when there were insufficient staff on duty to provide people with the care and support they needed.

People received their medicines as prescribed and medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not completely effective.

People's health was not being properly monitored or responded to appropriately.

People were supported by staff who received appropriate training and supervision.

People made decisions in relation to their care and support and where they needed support to make decisions they were protected under the Mental Capacity Act 2005.

People were provided with the support they required to maintain their nutritional needs.

Is the service caring?

Good

The service was caring.

People lived in a service where staff listened to them and cared for them in a way they preferred. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting.

Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Requires Improvement

The service was not completely responsive.

People's needs and wishes and how these should be met were not clearly described in their care plans. In general people were supported to have a social life and to follow their interests, although there were occasions this did not occur. .

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems followed to monitor and improve the quality of the service would not be relied upon to identify where improvements were needed.

People were involved in giving their views on how the service was run to a management team they found approachable and trusted.

Ash Lea House

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.

We inspected the service on 30 November 2016 and was unannounced. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with four people who used the service. Due to their communication needs we were not able to have extended conversations with some of the people we spoke with.

We spoke with two members of support staff, a senior care worker and the deputy manager. The registered manager was on annual leave so was not available for us to speak with. We looked at the care records of four people who used the service, medicines records of three people, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

Requires Improvement

Is the service safe?

Our findings

The systems in place to ensure information of a safeguarding nature was acted on appropriately were not always effective. People we spoke with and their relatives told us they felt safe in the service and we observed people looked comfortable with the staff who supported them. However we found that the registered manager had not always shared information about incidents with the local authority safeguarding team.

We saw that where people sustained an injury from an unknown cause these were recorded on a body map. However there were no records of any follow up or investigation into how some of these injuries were sustained. Additionally this information was not always shared with the local authority as the provider is required to in the event of an unexplained injury. For example one person's care plan contained body maps which stated the person had bruising from an unknown cause on two occasions and on one of these occasions had lost a toe nail. There was nothing recorded to show if these had all been investigated or consideration had been given to sharing the information with the local authority safeguarding team. Additionally one person who had a history of falling down stairs had fallen down some stairs during an incident where staff had clapped to get their attention. This may well have contributed or caused the person to fall. The registered manager had discussed this with the staff involved but had not shared the information with the local authority to ensure it was investigated appropriately.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of harm. We saw there was a range of risk assessments in place for areas individuals were at risk of such as falls, the environment and accessing the community. However one person had information in their care plan which stated they were at risk of self-harm. The assessment did not give detail of what type of self-harm, other than saying the person should be kept away from scissors and sharp objects. The assessments did not specify what the level of risk was and so staff would not have the information needed to protect this person from this risk. We saw the person had access to sharp implements in the kitchen and this was not included in the risk assessment to inform staff how to ensure the person was safe whilst in the kitchen. Additionally there was an oven in the service, which the deputy manager assured us was no longer used, and this had sharp metal strips hanging off it which could be a potential risk to this person. Following our inspection the registered manager told us they had removed the oven and were updating the person's care plan to reflect the risks.

People were not always supported by sufficient numbers of staff. During the night there were two members of staff who remained awake to support 13 people who used the service. Records showed that two of these people generally woke at 6am and both needed support from staff with personal care, and one of these people had been assessed to be at high risk of falls. Both people had anxieties and one of them displayed behaviour which may challenge staff and place other people who used the service at risk. Additionally there were occasions when one of these people needed the support of both night staff when their behaviour escalated. A third person did not sleep well and needed constant supervision from staff when they were

awake due to displaying behaviour which was a risk to themselves and other people who used the service. If both night staff were busy with other people, they would not be available to support and supervise this person. This meant there were insufficient staff available at night time to provide these people with the support they needed, and in addition there were no staff available to support the other ten people if the need arose.

We observed one person who was supposed to be receiving one to one support from staff during the day, due to the risk they posed to themselves and others. Their care plan stated 'staff to observe and monitor [person who used the service] at all times.' However we saw occasions when the person was out of the line of sight of staff. On one occasion when the person was alone in the lounge they threatened another person saying, "If you don't shut up I am getting up and you are having it."

We spoke with two relatives and received mixed comments about the staffing levels. One relative told us they thought there were enough staff generally but said, "I sometimes think there should be more staff. They told us there were enough staff when the service was calm, but at other times they felt there should be another member of staff. The provider had carried out a staff survey a few months prior to our visit and this included comments that staff did not feel there were enough staff to meet the needs of people who used the service. One member of staff had said, 'Need more staff on at weekends' and another had said, 'Dependency has changed for some service users and more staff are needed to meet their needs.' The only action recorded following this survey was for the issue to be discussed at a staff meeting, however no change was made to the staffing levels following the meeting. .

During the day some people who used the service went to a day service and on the day we visited only seven people were at home during the morning. When the remaining people returned from the day services we saw the communal areas became very busy with people's differing personalities and dynamics changing the quiet atmosphere. There were five staff on duty and two of these were committed to carrying out one to one activity with two people who used the service and a third was cooking the evening meal. This left two staff to support the remaining ten people who used the service.

The deputy manager told us that there were five staff on duty at weekends when all 13 people were at the service. Two of these people required one to one support. This left only three staff to attend to the needs of the remaining 11 people, one of whom needed to be observed at all times due to their risk to others. We found the support available to these 11 people was further reduced when other people had one to one support during the day. One person had only recently moved into the service and so would need additional support to ensure they settled into the service.

Following our feedback about our concerns at the staffing levels the registered manager took action and increased the staffing levels in the afternoon and at the weekend. They also put a third member of staff on duty at night. They told us this was on a trial basis to ascertain if this was needed.

We saw two people were at risk of falling and there was a care plan in place which detailed how the person should be supported to minimise the risk of falls. One person needed to wear specialist shoes when they went out into the community and we saw on the day of our visit the person was supported to wear these shoes when they went out, as detailed in their care plan.

People were supported by staff who recognised the signs of potential abuse and how to protect people from harm. Staff had received training in protecting people from the risk of abuse and staff we spoke with had an understanding of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the registered manager. They understood their responsibility to escalate their concerns to external

organisations such as the local authority if their concerns were not acted on. One member of staff told us, "I would go to [registered manager] and if things did not get any better then I would contact safeguarding." A health professional gave us feedback prior to our visit and they told us that staff were 'aware of safeguarding procedures.'

The registered manager had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the registered manager carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

People were living in a safe, well maintained environment and were protected from environmental risks. We saw there were systems in place to assess the safety of the service such as fire risk and the risk of legionella. We saw a fire risk assessment had been carried out in the service and this had resulted in a number of actions for the provider to carry out. We checked if some of the actions had been addressed and we saw they had, such as clearing an external fire exit route and fitting door closing mechanisms to the office doors.

We saw there were individual plans in place for people to inform staff of how they needed to be supported if they needed to be evacuated from the service in an emergency. People who used the service were also involved in completing a health and safety audit which was written in a format they would understand. Staff had been trained in relation to health and safety and how to respond if there was a fire in the service.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. One person told us, "They (medicines) are in my room but they are locked in a cupboard. They (staff) come to me and make sure I have them." We observed that staff gave people their medicines when they were supposed to on the day we visited.

We found the medicines systems were organised and that people were receiving their medicines when they should. Staff were following safe protocols for example completing stock checks of medicines to ensure they had been given when they should. There were protocols in place to ensure staff had information on when people should receive medicines which were prescribed to be taken when required (PRN medicines). Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines and them on a regular basis.

Requires Improvement

Is the service effective?

Our findings

People were not always given the appropriate support with their ongoing health conditions. Prior to our visit we were informed of a safeguarding investigation which was being carried out due to concerns over the management of one person's ongoing health condition. At the time of our visit this investigation had not been concluded. The deputy manager told us they had learnt lessons from this and that checks were made on other people's health conditions and how they were managed. However when we looked at two people's care records who had the same health condition we found that there were the same issues around the management of the condition.

One person's care plan detailed how their health should be monitored and provided guidance on when the person's GP should be contacted. We looked at some records that showed that there had been a recent occasion where if staff had monitored the person's health as described in the guidance the person's GP should have been contacted, but they had not been. We also identified there was conflicting information in the care plan as to when the GP should be contacted.
In another person's care plan it was recorded that the person needed their health condition monitoring and we found that there was a lack of information giving staff clear guidance on how this should be monitored, what the person's usual pattern was and at what stage to call the person's GP for advice. Records showed that the person's GP should have been consulted with as a result of a concern highlighted as part of this monitoring, however the person's records did not show any action had been taken to address this concern.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make decisions on a day to day basis. We observed people decided how and where they spent their time and made some decisions about their care and support. We asked people if they felt they were supported to make decisions and they said that they were. We also observed staff respecting people's decisions. For example staff were supporting one person, who required continuous monitoring, to go to their bedroom and the person clearly did not wish to go and went to another area of the service instead. Staff respected this and continued to support the person in the area they chose.

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.

One person lacked the capacity to make certain decisions and there were MCA assessments in place for aspects of their care, such as medicines and having a monitor in their bedroom. One decision had been made without an assessment being undertaken, however the registered manager quickly addressed this to ensure it was recorded why the decision had been made in the person's best interests.

People were supported by staff who had a knowledge and understanding of the MCA. Both staff we spoke with had a good level of knowledge about their duties under the MCA and how to support people with decision making.

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 on authorisations to deprive a person of their liberty were being met.

The registered manager had made applications for DoLS where appropriate. For example, we saw that the care records of three people we looked at contained a DoLS which had been granted as all three had been assessed as requiring support from staff if they went out into the community and they were not free to leave the service alone. The registered manager had also made further DoLS applications for other people to ensure that they were not being deprived of their liberty unlawfully.

People were supported by staff who were trained to support them safely. People we spoke with felt staff knew what they were doing. One person described a group of staff as, "The A team." Another said, "They (staff) are very good." Relatives told us they felt staff knew what they were doing. One relative we spoke with told us, "I have never seen anyone (staff) flounder. If they don't know anything they will go and ask, they are always very helpful." We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had regular supervision from the registered manager and were given feedback on their performance, and we saw records which confirmed this.
The provider told us in the PIR that the skills mix within the service met the needs of the people residing within the service. Staff we spoke with felt they were given enough training to enable them to carry out their role safely. Staff described a range of training available and when we tested their knowledge on some aspects of care delivery they were able to answer confidently. Staff said that if they asked for additional training this was given. One member of staff gave an example of this and said, "I asked for further hoist training" which they told us had been provided. Staff were also supported to undertake a qualification in health and social care work. We saw from training records that staff were being given training in relation to a range of areas. There were some gaps on the training matrix in relation to a small number of staff but the deputy manager said these staff had only recently joined the service and the training was planned for after their induction. We spoke with one member of staff who had recently started working in the service and they told us, "[Registered manager] is keen to get us all trained."

People were supported by staff who were supported to have the skills and knowledge they needed when they first started working in the service. Staff were given an induction when they first started working in the service. The deputy manager told us that new staff were completing the care certificate and several staff had completed this. The Care Certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support. We spoke with a member of staff who started working in the service several months prior to our visit and they confirmed they had received an induction and told us they felt confident to support people who used the service following the completion of this.

People were protected from the use of avoidable restraint. People who sometimes communicated through

their behaviour were supported by staff who recognised how to avoid this and to respond. There were plans in place informing staff of how people's behaviour should be responded to and the plans gave details of what may trigger the behaviour, how it would manifest and how staff should respond. For example one person used certain words when their behaviour started to escalate and the plan gave clear instructions on how staff should respond to this to reduce the risk of the behaviour escalating, including items which could be used to divert the person. This person was prescribed medicines to be given as a last resort when their behaviour escalated to a specified degree. We saw the use of this medicine was minimal and that prior to administering it staff were required to get authorisation from the registered or deputy manager. Staff were given training in relation to responding to behaviour using least restrictive methods and staff we spoke with had an understanding of people's behaviour and how best to support them.

People were supported to eat and drink enough. We spoke with people about the food and they told us they had enough to eat, and we observed people had access to food when they wanted to eat. One person told us, "Staff cook me meals." Another person said, "Staff cook lovely meals and if I don't like it they do me a frozen dinner." One relative we spoke with told us, "The meals are lovely. If [relation] hasn't eaten tea they will offer other alternatives." Another relative told us, "We visited in the morning and saw them (people who use the service) getting a cooked breakfast one Sunday. The food seems to be varied with vegetables and healthy food." We observed two people making their own lunch and helping themselves to snacks. One person told us they had been trying to lose weight and described how they were achieving this and said, "Staff help." We observed the main meal of the day cooked by staff and this looked appetising and nutritious.

People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. Where staff noted two people had unplanned weight gain which placed them at risk in relation to their health and staff had updated both people's support plan to include healthier eating. We saw from the records of one of these people that this had been effective and the person's weight had been decreasing.

We saw people were supported to attend regular appointments to get their health checked. One person told us, "They (staff) make an appointment with the doctors if I need to go." Staff sought advice from external professionals when people's health and support needs changed. For example staff were currently working with a psychotherapist due to one person who was requiring additional support due to changes in their health. We saw there was a range of external health professionals
involved in people's care, such as the Speech and Language Team (SALT) and orthotics.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the service. One person said, "It's lovely here duck. The staff here support you." Another person said, "I get on with them (staff)." One relative we spoke with told us, "They (staff) do an absolutely fabulous job." Another relative had commented at a recent meeting that when they took their relation out 'they were soon asking to come home.' Which they felt was a positive sign. A health professional gave feedback on the service prior to our visit and they told us, 'Overall, I found the staff to be dedicated and caring.'

We observed staff interactions with people and we saw staff were generally kind and caring to people when they were supporting them. People looked relaxed and comfortable with staff and we saw them show affection towards staff and smiling when they approached. One person became distressed at one point and a member of staff who was close by gave reassurance to the person and this resulted in them becoming calmer. Staff told us they enjoyed working for the service. One member of staff told us, "I love it, making people happy." We observed one negative interaction and this was responded to appropriately by the senior care worker and reported to the deputy manager. Observations and discussions with staff showed that staff clearly knew people's likes and dislikes and how they preferred to be supported. We saw in people's care plans that their preferences for how they were supported were recorded, along with their likes, dislikes and what was important to them.

People were supported to maintain relationships with their friends and family and to make new friendships with other people who used the service. One person described their friends visiting them at the service and said the staff made them feel welcome. They told us they had formed a friendship with another person who used the service. Another person told us, "I knew people already and said I wanted to live here." One relative told us, "When we visit we are always offered a cup of tea and [relation] is offered this too." Records showed that one relation had written to the registered manager following a recent visit to see their relation saying, "Thank you so much for yesterday, you were all so welcoming." A relative had also commented in a recent survey saying, 'The staff are all very helpful to [name]'s needs.' And 'Staff always make me welcome.'

People we spoke with told us they got to make choices for example about when and where they ate and how they spent their time. We observed people's choices were respected on the day of our visit. We saw one person who decided they wanted their evening meal in the 'quiet lounge' and this was facilitated. Two people chose to make their own lunch and we observed staff supported them with this and both people chose what they would like. We heard staff ask things like, "Would you like orange or blackcurrant (to drink)" and "What would you like for dinner." We saw that people were given the opportunity to make suggestions about food and activities at regular meetings held for people who used the service.

Care plans contained information guiding staff on what choices people were able to make themselves, such as deciding what to wear and what time they got up and went to bed. The plans included what people could do for themselves and what they would need support with and also how they preferred to be supported.

Some people who used the service needed support with their communication needs due to limited verbal

communication. We saw there were communication passports in place which were very detailed and covered all ranges of people's communication needs. For example one person who had limited communication had details in place to ensure staff knew how they expressed themselves and what their body language and facial expressions might be communicating. The plans included guidance on how staff should respond to this to ensure the person's needs were met.

We saw that people had bedrooms which were personalised to their tastes, for example one person had a love of a particular singer and we saw their bedroom contained pictures of this singer, which the person would enjoy looking at. One person told us, "My bedroom is lovely with new furniture and new bedding." There were various communal rooms for people to choose from if they wished to sit in different areas. There was a main lounge and dining room and an additional 'quiet lounge' which led to a further seating area and games room in a conservatory. One relative told us, "We are grateful for [relation] being in that home. It's big and warm and has many rooms for them."

We saw that people and their significant others had been supported to develop a plan for when they reached the end of their life. These were written with involvement from the person they were intended for and from their significant others. We saw the plans took into account all aspects of the support people wished to have when they reached the end of their life.

People had opportunities to follow their religious beliefs and had access to advocacy services. One person chose to follow their religious beliefs and the deputy manager told us this person was supported to attend their chosen place of worship each week. The person confirmed this when we spoke with them saying, "I go to church on a Sunday." We spoke to the deputy manager about the use of advocacy services for people, an advocate is a trained professional who supports, enables and empowers people to speak up. The deputy manager told us that three people were currently using advocacy services and we saw there was information displayed in the service informing people how they could access an advocate.

People were supported to be independent. For example, we observed two people who prepared their own lunch and they looked happy and engaged in this. One person spent time cleaning their bedroom and helping staff to undertake other daily living tasks throughout the morning. The person's care plan stated this was important to them as they wished to learn new daily living skills. We saw people's levels of independence and what they could do for themselves, and what they would need support with, were detailed in their care plans.

People told us they felt their dignity was respected and that they could have privacy when they wanted. One person told us, "My room is my room." Relatives we spoke with felt staff were respectful and said that their relation was afforded privacy when they wanted it.

We observed staff were mindful not to have discussions about people in front of other people and they spoke to people with respect. Staff told us they were given training in privacy and dignity values during induction and staff we spoke with showed they understood the values in relation to respecting people's dignity.

Requires Improvement

Is the service responsive?

Our findings

People were supported by staff who were given information about their support needs. We saw people had a care plan in place to give staff the information they needed to meet the needs of the individual. We saw that people's care plans contained information about their physical and mental health needs and guided staff in how to support them.

However we found that not all needs were planned for. One person had a plan in place which stated they would like to have a personal relationship but the plan did not contain information to guide staff in supporting the person to try and establish a positive healthy relationship. We also found that the care plans were very repetitive and this resulted in them being very large documents for staff to read and review. For example one person who needed support due to having behaviour which may challenge staff had four different assessments and plans in place for this. Additionally the risk assessment in place for this was very long but did not capture specific detail of how the person should be supported in relation to each area of risk. We found this to be the case for each area of need and not only would this result in staff having to read information about each area of need in several different plans, it meant all versions of the plan would need to be updated when the person's needs changed. We found this resulted in conflicting information in some care plans with one plan giving certain guidance and another plan conflicting this guidance. For example the care record for one person stated they were able to access the internet independently but another stated their internet access needed to be restricted, stating 'staff not to pass internet code and observe phone use closely.' We observed the person accessing the internet on their mobile phone freely.

We received positive feedback about the service from a visiting health professional prior to our visit, however the professional commented on the amount of paperwork the registered manager had to do. They told us, "The manager seemed overwhelmed with paperwork, but was very caring towards the residents and responded to their needs."

We found mixed evidence of people being supported to follow their hobbies and interests and being supported to go out into the community. One person told us, "I go out whenever I want. I sometimes go uptown. I have enough to do with my time." Another person had been supported to get work as a volunteer for an organisation and staff supported them to do this. We saw some people were supported to attend a day service to take part in activities on a regular basis. On the day we visited some people were at the day service and another was taken out by staff as part of their one to one support. Relatives commented positively about the activities with one saying, "They take them out for the day and are always trying to do activities and keep [name]'s mind occupied. They hold discussions about what is current on the news. The activities are good." Another said, "[Name] is taken out a lot more than at the last home. [Name] goes up to the shops to the pub for drinks and meals. [Name] has been to Skegness three times in the last year."

However we saw that people did not always receive the activities as scheduled. For example we saw in one person's care plan that staff had detailed it was very important for this person to have a structure each day as otherwise this could have an effect on their behaviour. We looked at the activities and structure this person had over a seven day period and the records kept of what activities they had taken part in. These

showed the structure was not always being adhered to. We saw records of the person's monthly keyworker meetings for the two months prior to our visit and the keyworker had also recorded during both meetings that staff were not always carrying out the planned activities with the person. In a further person's activity records we saw that on some days staff were not recording any activities, despite the person receiving one to one support to enable them to keep active and access the community.

There had been a Halloween party held in the service and there were plans for a Christmas party, and relatives had been invited to both of these events. One person told us, "We have a Christmas party every year and one year we had an Elvis man." Another person told us, "I go uptown to the coffee shop. I got to the market sometimes." A third said, "I went to Skegness with [deputy manager].

People were involved in planning and making choices about their care and support. The provider told us in the PIR that regular care reviews were held with people who used the service, their family members and care management. The deputy manager told us that each person had a key worker (a named member of staff who was responsible for overseeing their care and support) and that the person and their keyworker met each month to discuss if they wanted any changes to their support. We saw records which confirmed these meetings were taking place and these included setting goals for the person to achieve the next month. We saw that one person was being supported to write their own daily log of what they had done that day so they were in control of what was recorded about their day. The deputy manager told us that people, where they were able, were involved in the preparing of their care plans and we saw this was the case with some people signing their care plan to say they were happy with them. Relatives told us they were contacted if there were any changes to their relation's health and that they had the opportunity to contribute to care reviews. One relative told us, "They (staff) always inform us when [relation] has been to the hospital or the chiropodist." Another described six monthly care reviews they took part in.

The deputy manager told us they felt the service was good at adapting to meet people's changing needs. They went on to say that as people grew older their needs changed and staff were good at adapting the support they gave to meet these changes. A health professional agreed with this when they gave us feedback prior to our visit saying, 'I often observed them (staff) adapting their practice in response to the resident's needs. They understood and implemented person centred care.'

People knew what to do if they had any concerns. We saw that the complaints process was discussed with people who used the service and their relatives at regular meetings where people were given the opportunity to raise any concerns. The people we spoke with told us they would speak to the registered manager if they had a problem or concern. They told us they felt they would be listened to. One person told us, "I would tell [registered manager] she's the boss, but I have no worries here." Another person told us, "I would go to the manager or head office." Relatives we spoke with told us they would feel confident in raising issues and felt they would be addressed. One told us, "In the time [name] has been there we have never had a problem." Another said, "If we had any concerns we would speak with [registered manager]."

The deputy manager told us they had received one complaint in the last two years. Records of this showed it had been responded to appropriately and information shared with us and the local authority safeguarding team. Staff were aware of how to respond to complaints and the registered manager had systems in place to deal with complaints if they arose. There was a complaints procedure in the service so that people would know how to escalate their concerns if they needed to.

Requires Improvement

Is the service well-led?

Our findings

Systems in place to monitor and improve the quality of the service people received were not always effective. The deputy manager told us there was a system in place to analyse incident records to ensure all required actions had been taken, however we found some incidents which had not been shared with the local authority safeguarding team which meant the system was not effective in ensuring the required action had been taken. Additionally there was no effective system in place to check other records such as health charts to ensure staff were recording appropriately on these and that action had been taken if there were any issues in relation to people's health and wellbeing as a result.

One person was having their food and fluid intake monitored and staff were supposed to detail all intake on a food and fluid chart. We looked at the person's food and fluid records and we saw there were frequent gaps in these and staff were also not always recording the amount the person had consumed. Another person had activity records in place and their care plan stated that staff should record all activities. We looked at a sample of these records from October and saw that out of five days only three contained records of the activities the person had taken part in. The failure to complete these records meant that people's care and support could not be effectively monitored to ensure this was being provided as intended to meet people's varying needs.

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

People we spoke with told us they were happy living in the service and the relatives we spoke with also commented positively on the service and said they felt their relation was happy there. One relative told us, "We looked at other homes and we all wanted Ash Lea House." Another relative told us, "When we visit people look well looked after."

There was a registered manager in post and people we spoke with knew who the registered manager was and spoke positively about her. One relative told us, "[Registered manager] has been absolutely fantastic." Another relative said, "[Registered manager] always comes across as a nice and fair lady." On the day we visited the registered manager was on annual leave and we were assisted by the deputy manager. It was clear from discussions with people and from our observations that the deputy manager had a positive relationship with people who used the service and with staff. Records showed that the registered manager and deputy manager had notified us of significant events in the service.

Staff also commented positively about the registered manager and the deputy manager. One member of staff told us, "Management is responsive to suggestions and changes. It is an open door, I can go to them with anything. [Deputy manager] is brilliant." Staff were given the opportunity to have their say about the service during regular meetings and by completing surveys sent to them. The provider had a dedicated whistle blowing department and staff we spoke with told us they would feel confident to use this if they needed to raise concerns about the service. One member of staff told us, "I would take it to the manager and then I would phone the company's whistle blowing number."

People who used the service and their relations were given the opportunity to have a say about the quality of the service. There were meetings held for people who used the service and also for their relatives so the provider could capture their views and get their suggestions and choices. One relative told us, "They have a relatives meetings and we meet any other relatives who are going to be there. We can discuss any issues we have there." We saw the minutes of the last two meetings for people who used the service and for their relatives and saw people had been given the opportunity to have their say about the service. The deputy manager told us that feedback forms were sent to people who used the service and their relatives every six months. We looked at the results of the last survey and saw these had been analysed and shared with people and an action plan was put into place for any areas which needed addressing. For example some relatives had said they were not aware of the statement of purpose for the service and so a copy of this had been sent out to them. We saw on the whole the feedback was positive and people who completed the surveys were happy with the service.

We saw the registered manager and deputy manager undertook regular audits of the service in relation to medicines, infection control and health and safety. Any issues which were noted were included in an action plan to make sure the improvements were made and actions were followed up.

The provider oversaw the running of the service and ensured people were happy with the service being delivered. The provider had a senior manager to represent them and undertake visits to the service. The deputy manager told us that the provider visited the service every two months or more frequently if additional support was needed. We looked at the records of the most recent visit undertaken and saw the provider conducted a tour of the service, spoke with people who used the service and checked that areas of work such as audits were up to date. We saw the provider gave the registered manager an action plan following each visit. We looked at two actions from the most recent visit and saw one had been completed and the other was in the process of being completed on the day we visited.

The provider shared information across the group of services they operated through regular organisational newsletters for managers with updates and information sharing. These were used to communicate where improvements were needed in services, including accidents, near misses, survey results, complaints and corporate feedback. The managers of the services used an electronic monthly return to feed into the overview of the service and this formed a part of the newsletter with details of incidents and lessons learned with feedback given to managers so that learning could be shared across the organisation.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always assessed and planned for appropriately and steps were not always taken to mitigate risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not always operated effectively to minimise the risk of abuse. Regulation 13 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality of the service were not always effective in identifying where improvements were needed. Records of care and treatment provided were not always robust. Regulation 17 (1)(2)(a)(b)(c)