Indigo Care Services Limited

Ashbury Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 30 November and 1 December 2016 and was unannounced.

Ashbury Court provides accommodation and personal care for up to 37 older people. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. There were 34 people living at the service at the time of our inspection. The service is situated next door to another care home service run by the same provider and shares staff and management with the other service.

The registered manager was leading the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was supported by a deputy manager who had been appointed shortly before our inspection. They gave us records we needed during the inspection. The previous deputy manager was working at the service next door and gave us information about people and other records relating to moving and handling, training and people's care needs.

The provider and registered manager did not have oversight of the service. They had not supported staff to provide a good level of care or held staff accountable for their responsibilities. Checks on the quality of care being provided had been completed but the shortfalls in the service we found at the inspection had not been identified.

Risks to people had not been consistently identified, assessed and reviewed. Action was not always taken to reduce risks. Detailed guidance was not available to staff about how to keep people safe.

Staff did not have the skills they required to keep people safe in an emergency. Action had not been taken to mitigate risks identified in the fire risk assessment, including risks relating to the building. Following our inspection we informed the local Fire and Rescue Service about the risks we found.

Assessments of people's needs had not been consistently completed. Staff had not always acted on identified risks to keep people safe and well. Detailed guidance had not been provided to staff about how to meet people's needs. Staff did not always follow the guidance provided to support people to remain independent. One person's needs had not been assessed and no guidance had been provided to staff about how to provide their care.

Changes in people's health had were not always recognised quickly and acted on. One person told staff they felt unwell and wanted a doctor. Staff had not acted on the person's request and they were later admitted to

hospital. People had been supported to have regular health checks such as eye tests. Recommendations made by healthcare professionals following these tests had not always been followed to keep people as safe and healthy as possible.

People's medicines were not always stored securely and there was a risk that people could take medicines that were not prescribed to them. Medicines were not recorded accurately, including why people's medicines had been changed.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people were restricted.

Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). Assessments had not been completed of people's capacity to make specific decisions. People who knew people and their wishes well had not been included in making decisions in people's best interests. Care staff assumed people could make day to day decisions, however, guidance was not provided for staff about what decisions people were able to make.

Staff had completed training in key areas but had not completed training to make sure they had the skills to provide effective care to everyone, such as communication training.

Accurate records were not maintained about the care people received and their medicines. Information was not available to staff and health care professionals to help them identify any changes in people's needs. People's personal information was stored safely.

Action had been taken to resolve people's complaints to their satisfaction and use them to improve the service.

People and their relatives were asked for their views of the service. However, staff and other stakeholders such as district nurses and GP's had not been asked for their feedback on the quality of the service to help the provider identify shortfalls and continually improve the service.

People had to wait for the care they needed, for example, support to walk to the toilet. The registered manager had not made sure sufficient staff were deployed at all times to meet people's needs.

People told us they had enough to do during the day. They were involved in planning and taking part in a wide range of activities. People made craft items such as Christmas decorations which they sold to staff and visitors.

Safe recruitment procedures were followed for staff. Gaps in employment had been questioned. Staff regularly met with the registered manager to discuss their role and practice and told us they felt supported. Staff knew the signs of possible abuse and were confident to raise concerns they had with the registered manager.

Although people told us staff were kind, people were not always treated with respect. For example, the registered manager referred to people as 'naughty' throughout our inspection. People's tea was made with milk in a pot and not to their preference.

People told us they liked the food at the service but their meals were often cold. Meals were balanced and

included fruit and vegetables. All meals were homemade. People were offered a choice of food to help keep them as healthy as possible.

The manager had notified CQC of significant events that had happened at the service. Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not always assessed. Action had not been taken to support people to be as safe as possible.

Detailed guidance and training had not been provided to staff about how to keep people safe in an emergency.

People's medicines were not stored safely or recorded accurately.

People told us there were not always enough staff to help them when they needed it.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Staff knew how to recognise signs of abuse.

Is the service effective?

Inadequate

The service was not effective.

Care had not been planned to meet people's health care needs. Action was not always taken when people asked to see a doctor.

Staff did not always follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People's relatives had not been involved in making decisions in their relative's best interests.

Staff had not completed all the training they needed to meet people's needs.

People told us they liked the food at the service but it was often cold. People were offered a balanced diet and were involved in planning the menu.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always described in respectful terms. The registered manager described people as 'naughty'.

Staff knew people's likes, dislikes and preferences and information about some people's life before they began to use the service. This helped staff get to know people and how they preferred their care provided.

People said that staff were kind and caring to them. People were given privacy.

Is the service responsive?

Inadequate

The service was not responsive.

Assessments of people's needs had not been completed. Detailed guidance was not available to staff about how to meet each person's needs.

People planned and took part in a range of activities they enjoyed.

People's complaints had been resolved to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

Checks the provider and registered manager completed on the quality of the service were not effective. The checks had not found the shortfalls we identified.

Action had not been taken to regularly obtain the views of staff and health professionals.

Records about the care people received were not consistently accurate and there was a risk that people would not receive consistent care.

The registered manager had not made sure staff knew about their responsibilities. Staff were not always held accountable for their practice.

Ashbury Court

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.

This inspection took place on 30 November and 1 December 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, we did not ask 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. This was because we inspected the service sooner than we had planned. We looked at notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We reviewed information we had received from people's relatives and whistleblowers.

During our inspection we spoke with seven people living at the service, three people's relatives and friends, one GP, the registered manager, the deputy manager and the previous deputy manager, the operations manager and ten members of staff. We visited some people's bedrooms with their permission; we looked at care records and associated risk assessments for five people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at medicines records and observed people receiving their medicines.

This was the first inspection of Ashbury Court under the ownership of Indigo Care Services Limited.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. People's relatives commented, "I feel [my relative] is safe" and "There is no way I would leave [my relative] where they were not safe". However, we found that people were not always safe at Ashbury Court.

Risks to people had not been consistently identified, assessed and reviewed. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe. Assessments of the risks to one person had not been completed. Risk assessments for other people had not been completed correctly.

One person's malnutrition and dehydration risk assessment showed they had lost weight in April, June, July, August and October 2016. The registered manager told us their weight audits had identified the person had lost weight but they did not know what action had been taken to reduce the risk to them. The person's GP told us they did not know that the person had lost weight. The registered manager referred the person to a dietician during our inspection. Other people's malnutrition and dehydration risk assessments had not been completed correctly so it was not clear to staff if they were at risk or not. Increasing risks including people losing weight had not been identified and action had not been taken to keep people as safe as possible.

Risk assessments had not been completed to identify the support people needed to move safely. Each person who was moved using a hoist had been provided with a hoist sling. One person's care plan stated they used a 'toileting sling' for all transfers. We asked staff why the person used a toileting sling rather than a standard sling. A toilet sling is usually used only to transfer people onto and off of the toilet as it offers less support than a standard sling. The previous deputy manager told us this was the only sling at the service that was the right size for the person. We asked staff if they had taken action to obtain a standard sling for the person, they told us they had not. They had not taken action to obtain the most appropriate sling for the person.

People were not provided with different slings to support them to move safely between different pieces of equipment such as chairs and beds. When slings were being washed people had to use someone else's sling. The risk of people falling from a hoist sling is increased when the incorrect sling is used to move them.

Risks to peoples' skin health, such as the development of pressure ulcers, had been assessed. Clear guidance had not been given to staff about the support people should be offered to keep their skin healthy. For example, one person's care plan stated, 'Staff to ensure [person's name] is on their pressure mattress and their heel has appropriate cushioning underneath'. The registered manager told us the person had been provided with cushioned boots to keep the pressure off their heels, but no longer needed them. We observed the person sitting in a recliner chair, on one occasion they were wearing the boots, on another occasion they were not. Reviews of the person's risk assessment had not identified a change in their needs and staff were not clear about the support the person needed to keep their skin healthy.

Pressure relieving equipment was available to people who needed it, however, the provider had not given

the registered manager clear guidance about how to set some pressure relieving equipment pumps to make sure mattresses offered people the maximum benefit. The registered manager had requested guidance from the provider's purchasing department several times before our inspection but had not received a satisfactory response. Using a pressure relieving mattress that is too firm or soft may not give people the best protection from developing skin damage. During our inspection the operations manager requested the same information. After our inspection the registered manager told us they had received the information they needed to use the pressure relieving equipment correctly. We will check that the equipment is used correctly at our next inspection. Guidance had been provided to staff about the use of other pressure relieving equipment pumps.

The registered manager told us they reviewed and analysed accidents to look for any trends or patterns to see what action should be taken to reduce the risk of them happening again. However, accidents had not always been recorded. One person's records stated, 'A couple of times tried to get themselves in bed and fell on their bottom'. The accidents had not been recorded and the registered manager had not been informed. The person's risk of falling had not been assessed and action had not been taken to reduce the risk of the person falling again.

There had been occasions when people displayed behaviours that may challenge. These incidents were not regularly documented by staff. We asked the registered manager if we could see incident forms relating to one person's behaviour. They told us these had not been completed, as the person's behaviour was, "Just part of what the person used to do". Staff told us they 'sometimes' completed behavioural charts if a person displayed behaviours that challenged. Information about people's behaviour was not available to visiting care professionals who supported them, such as care managers or the mental health team so that they could review them to look for any patterns.

A building fire risk assessment was completed by a specialist company in March 2016. This identified a number of risks and recommended action was needed over the following three months. Action had not been taken to mitigate the majority of the risks, including some assessed as high risk. The risk assessment stated, 'Unless a suitable additional escape route is provided, ensure that the first and second floor levels are only occupied by residents who are able to walk down stairs'. The registered manager told us this was not a practical option and people who were not able to walk down the stairs had bedrooms on the first and second floors. The provider had not taken action to add an additional escape route as recommended.

A fire evacuation plan was in place. There were no separate evacuation plans for the night time when there were less staff on duty. Fire evacuation equipment was available. Some staff had completed on-line fire evacuation training and had practiced using the equipment once. The registered manager had observed staff using the equipment but did not know if they were using it correctly. Staff said they were not confident to use the equipment. The provider and registered manager had not taken action to assure themselves that all staff had the skills they needed to keep people safe in an emergency.

Two people did not have personal emergency evacuation plans (PEEPs). Other people's PEEPs had not been updated to include the new evacuation equipment because not all the staff had completed the training the provider required. PEEPs did not include guidance to staff about how to move people to keep them safe in an emergency. Following our inspection we informed the local Fire and Rescue Service about the risks we found. Regular tests were carried out on extinguishers, emergency lighting and fire doors.

The provider and registered manager had failed to assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff managed their medicines for them. One person told us, "I prefer staff to do my medicines, it's safer". Another person told us, "Staff see to my medicines, they come round to give me what I should have." However, we found that people were not protected from the risks of unsafe medicines management.

Medicines were not stored securely. The medicines trolley was left open and unattended in the dining room at breakfast time. The room was busy with people, staff and visitors coming in and out, walking past the open trolley. There was a risk that people, visitors and staff could remove medicines from the trolley. Medicines were stored at the correct temperature.

One person was prescribed medicine as, 'Take one at night'. Their medicines administration record (MAR) showed they had declined to take the medicine at times. Staff had begun to administer the person's medicine in the morning. The registered manager did not know why the time the person was offered the medicine had changed or who had made the decision. The change was not recorded in the person's records. The registered manager contacted the person's GP and pharmacist during our inspection; neither had changed the time the medicine was administered. The person was not receiving their medicine as directed by their doctor.

Some people were prescribed medicines 'when required', such as pain relief and inhalers to help them breathe more easily. Detailed guidance had not been provided to staff about the 'when required' medicines each person was prescribed, such as when it should be offered to people and how people might tell staff they needed it. One person's 'when needed' medicine had been administered every day and there was a risk they were either not getting the maximum benefit from it or were taking too much. The registered manager had not arranged for a medicine review.

Before our inspection concerns had been raised about the accuracy of records relating to medicines. We looked at people's MARs and other records used to monitor the administration of medicines. The reason people had stopped taking medicines had not been recorded on their MARs or other records. One person had stopped taking an antibiotic and had started to take another. Staff did not know why the person's medicines had changed. The registered manager told us the person's GP had called and changed their antibiotic. They confirmed that they had not recorded this in the person's records or on their MAR.

Some entries on people's MARs had been handwritten. These had not been checked by a second staff member to reduce the risk of mistakes. Records were kept of the administration and stock balance of some medicines. Some entries had been 'scribbled' out and it was not clear how much stock of the medicine was held. Staff and the registered manager did not know that this practice was not safe. There was a risk that checks of the stock balances would not be completed accurately.

Creams had been prescribed to many people to keep their skin as healthy as possible. People told us staff applied these for them every day. Records had not been kept each time the creams were applied, for example one person's topical medication administration form had not been completed between 11 and 22 November. The registered manager told us the creams had been applied to the person, but staff, "Could not be bothered" to complete the form. They had not taken action to make sure that topical medication administration forms had been completed accurately and checks had not been completed to make sure people's creams had been applied as prescribed. Guidance had been provided to staff about where each cream was to be applied.

Senior care staff had completed medicines management training and their competence was assessed regularly. The registered manager told us the competency assessments were not effective as staff did not

always follow safe medicines processes. They had not taken action to make sure staff always managed people's medicines safely.

We observed people receiving their medicines. This was done in a caring and respectful way. Staff reminded one person, "Don't forget this one, you need to suck it". Another person was offered their favourite drink to take their medicines with.

The provider and registered manager had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we received concerns that staffing levels were reduced at times and this meant that people had to wait a long time to receive the care they needed. One person told us, "They don't come immediately when you press the bell. Not when you want to spend a penny, that is one of the problems. You can wait a long time for someone to come". Another person became distressed at breakfast time when they were not able to get the attention of staff to tell them they needed help to walk to the toilet. A third person said, "I'd like to go out for a look around the shops but staff don't have time to take me". A visiting health care professional told us, "I think at times they can have problems with staff shortages". One staff member said, "Generally there are enough staff, but sometimes we struggle. We can't rush the residents though, the care must come first". People we spoke with told us they were not rushed.

The registered manager used a dependency assessment to decide how many staff were needed to meet people's needs, however this was not effective. We observed that some people had to wait for their lunchtime meal and had to wait for support. People in the dining room received their meals between 13:00 and 13:15 and were supported by two staff. People who had chosen to eat in their bedrooms did not receive their meal until 13:30. One person who was sitting in the lounge next to the dining room did not get their meal until 13:45, they were asking for their meal. Staff had not been deployed to make sure that people received their meals quickly or did not have to wait for the support they needed.

The registered manager told us that they were not able to arrange cover quickly when staff called in sick at short notice, which happened often. Cover was usually provided by other members of the staff team who attended as quickly as they could when they were asked to cover, but this may be two hours after the start of the shift. At times this meant that staffing levels were reduced at busy times including when people wanted to get up, washed and dressed in the morning.

Many day shifts began at 8am and ended at 8pm, night shifts started at 8pm and finished at 8am. Staff said, "Twelve hour shifts are a killer" and "Twelve hour shifts can be tiring, but it is not too bad". Staff or people had not been asked for feedback on the length of their shifts and if this had an impact on their ability to provide the care people needed.

The provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recruitment policies and procedures which were followed by the registered manager. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with vulnerable people. A full employment history had been gained for each member of staff. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working

with people who use care and support services.

Staff knew how to recognise and report different types of abuse. They had received safeguarding training and information about abuse. The Kent and Medway safeguarding protocols were available for all staff to refer to if needed. Staff told us they would report any concerns to the registered manager. One member of staff said, "I'd look out for any changes in behaviour or if people seem quiet or down. Plus the obvious stuff like bruises. Any concerns and I'd go straight to my senior or manager." Staff were confident that the registered manager would act on any concerns that were raised. The registered manager was aware of their safeguarding responsibilities. Referrals had been made to the local safeguarding authority when required and action had been taken to reduce the risks of incidents happening again.

People's money was managed safely. The registered manager kept small amounts of petty cash for most people, so they could make small purchases as and when they wanted to. They regularly checked that receipts matched what had been spent for each person and that the total amount of money was correct.

Inadequate

Is the service effective?

Our findings

Care had not been provided to keep people as healthy as possible. We visited one person in their bedroom with the registered manager. The person had an infection and told the registered manager, "I keep telling everyone I feel ill. I don't have a specific pain, I just feel ill. I have been asking for a doctor but no one is listening to me". Staff took the person's blood pressure at the registered manager's request and found it was very low. They called an ambulance and the person was admitted to hospital.

The person's GP had informed the registered manager they suspected the person had an infection and needed 'plenty of fluids'. The person did not have drinks within their reach when we visited them. Staff did not know that the person needed to be encouraged to drink and care had not been planned to make sure the person was offered drinks often. Detailed records of the amount the person drank had not been kept so staff could check they were drinking enough.

Guidance provided by health care professionals had not been used to plan people's care. One person had lost 10% of their body weight. In October 2016 a dietician had recommended the person have a high calorie diet including one pint of fortified milk a day and to eat high calorie foods 'little and often'. The person's care had not been planned to include the dietician's advice and the person had not been offered fortified drinks and foods as suggested.

Information about people's health conditions was not always correct. One person's care plan stated they had Parkinson's disease. The person's GP told us the person did not have Parkinson's disease. Another person's psychiatrist had stated in a letter that they had 'epilepsy that was well controlled.' Staff and the registered manager were unaware that this person may have epilepsy and had not spoken with the person's GP to check that this information was correct.

People were supported to access regular eye tests. However, recommendations made by people's opticians had not been followed to support people to see as well as possible. An optician had identified in April 2016 that a person had cataracts and this was affecting their sight. This was impacting on the person's mobility as they were unable to see where they were going. The optician had advised that staff to speak with the person's GP about the cataracts being removed. Seven months later this had not been followed up and the person's GP was unaware that this recommendation had been made.

One person's relative told us, "The staff called the GP when my relative was unwell. It was just a usual water infection but they kept me informed". People were supported to attend health care appointments by their family or staff. This was to offer people reassurance and support them to tell their health care professional about their health and medicines. A chiropodist visited people regularly.

The provider and registered manager had failed to ensure people were safe and had the support they needed to manage their health needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Five staff had not completed training on mental capacity and one member of staff told us, "I can't think what DoLS are". The registered manager had completed training on mental capacity but did not understand the action they needed to take to make sure they acted within the principles of the Act.

The provider had a process to access people's capacity to make particular decisions but this was not completed correctly to make sure that people participated as much as possible in making decisions about them. For example, the registered manager had assessed that one person did not have the capacity to make the decision 'communication'. The person required support from staff to communicate their needs but did not need to make any decisions about their communication. Guidance had not been provided to staff about how to support the person to communicate their choices and decisions. The person was not offered choices in ways they understood during our inspection.

One person had bedrails on their bed to reduce the risk of them falling out. The registered manager and previous deputy manager had assessed that the person did not have the capacity to make a decision about using the bed rails and had made a decision in the person's best interests. The person's relative who knew them better than the registered manager and previous deputy manager visited them several times a week. They had not been asked to be involved in making the decision in the person's best interests.

Some people needed support to make decisions and tell staff what they wanted. We observed people were not always supported in ways they preferred to make day to day decisions such as what they wanted to eat or drink. Guidance had not been given to staff about how people would tell them what they wanted. For example, one person's care plan stated, 'No communication skills' but staff told us the person could make day to day decisions by saying 'yes' or' no'. There was a risk that they would not be consistently supported to make decisions.

Other people we spoke with said they were able to tell staff what they wanted and staff respected their choices. One person told us that staff showed them items from their wardrobe each morning until they decided what they wanted to wear. Staff showed some people two meals at lunchtime to help them choose the meal they wanted, other people who were at risk of choking were not given a choice. Staff told us they did not assume people were unable to make a choice for themselves. One member of staff said, "If I thought [the person] might need the toilet I'd show them their commode, if they push it away then that means they don't need to go, but if they walk to towards it then obviously I would assist them". We observed that this philosophy was not followed consistently and staff did not always offer people choices in ways they understood.

The provider and registered manager had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Due to a restriction, one person was the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. Care had not been planned to make sure restrictions to people's liberty were minimised. People told us they did not go out but would like to. People's relatives had asked for their relatives to be taken out but this had not happened. The registered manager told us that it was the provider's policy to charge people for any support they need from staff to go out. People and their relatives had not been given information about how to request staff to support to go out and how much this would cost them. The registered manager had not taken action to support people to go out when they wanted to. This was an area for improvement

New staff worked through induction training which included working alongside established staff. They completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

Staff had received training in key topics such as safeguarding and first aid. Competency assessments had been carried out to check staff's understanding of a range of topics, including treating people with respect and dignity and accurately completing paperwork. However, at our inspection we found gaps in a variety of paperwork and that people were not always treated with respect. The registered manager told us, "I don't think the competency assessments are worth the paper they are written on. One day I'll sign people off and the next day they won't do what they are meant to be".

Staff had not received training in topics specific to people's needs such as mental health or learning disabilities. The registered manager told us six people using the service had a learning disability. Staff did not know how to support people with a learning disability to be involved in planning their care to reduce the risk of them becoming anxious or frustrated. For example, one person asked staff for a chocolate bar and was told they could not have one because they were 'on a diet'. The person repeated the question several times and received the same answer from staff. They became angry and started shouting. The registered manager told us the person enjoyed eating chocolate and could have a bar on occasions as a treat. This was not planned to make sure it happened regularly so the person knew when they would be offered the chocolate. The registered manager told us the person liked to have something to look forward to. They had not considered using a diary or calendar to plan with the person when they would be offered the chocolate bar.

Some people needed support with their communication and staff had not received any training in how to assist them. The registered manager told us that one person's speech was "difficult to understand". We observed they were not able to understanding everything the person told them. The person was anxious about missing a party they were looking forward to and did not receive the information they needed to reassure them. The person asked about the party again the following day and again was not given the information they needed in a way they understood. We spoke with the person and had no difficulty understanding what they were telling us. There was a risk that the person would not be offered the support and reassurance they needed as staff did not always understand what they said. Action had not been taken to support staff to develop the skills they needed to communicate with the person.

Staff told us they felt supported and that they had the opportunity to attend regular staff meetings and one to one supervision meetings. The registered manager organised regular supervision meetings with staff in advance. This gave staff the opportunity to talk about any training and development needs.

The provider and registered manager had failed to appropriately support and train staff to be competent to

fulfil their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food at the service was cold at times. One person told us, "The last few days the porridge has been nice and hot but often it's cold by the time we get it. We have to wait for everyone to come down for breakfast". A person's relative told us, "[My relative] 'moans' about the kitchen. Sometimes their porridge is cold".

Kitchen staff were not always aware of important information about people. For example, one person's health care professional had advised they had food and drinks fortified with additional calories. This information had not been given to staff in the kitchen who prepared the person's meals and drinks.

Meals were prepared to support people to stay as healthy as possible. Kitchen staff knew which people were at risk of losing weight were offered milkshakes and meals fortified with full fat milk, cream and other high fat products. People who required a low sugar or reducing diet were offered low sugar alternatives of other foods.

Menus were varied and meals were balanced, with fruit and vegetables. All meals were homemade. Catering staff were aware of any changes in people's likes, dislikes and needs. The activities coordinator discussed the menus with people. Their suggestions were acted on, including taking spaghetti off the menu as people did not like it and increasing the number of times fish pie was offered. Kitchen staff knew people's birthdays and made them birthday cakes.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff at Ashbury Court were 'kind'. Their comments included, "It's a very nice home. I couldn't be anywhere better" and "The staff are very good to me, they are very kind to me". We found that staff did not always provide people's support in a caring way.

Staff did not always treat people with respect, including the language they used when they spoke to people and wrote in their records. One person's care plan stated, 'Requires feeding' to inform staff the person needed assistance at mealtimes. Another person's care plans described them as 'spiteful'. A third person's behaviour was described as 'a weapon to control carers.' The registered manager referred to several people as 'naughty' throughout our inspection. They had not considered the language they used to describe people might be disrespectful.

One person's relative told us, "My relative has told me that three or four people need assistance with eating. Some staff were coming along, giving them a spoonful of whatever and then wandering off and then coming back 10 minutes later so people had cold food". We observed that one person was supported to eat their meal by two staff members. The first staff member supported the person with their main course and walked away when the person had finished. They did not speak to the person, tell them what they were eating or tell them who would support them with their pudding. A second staff member helped the person with their pudding, again they did not speak to the person or tell them what they were eating.

Staff did not support people to make everyday choices. For example, tea was made in a teapot with milk. People were not able to add milk to their tea as they preferred. The registered manager told us, "We always make white tea in the teapot". They had not recognised that this prevented people making choices about their tea. People were able to add milk to coffee and sugar or sweetener to drinks. A clear biscuit barrel and several types of biscuits were available in the kitchen. Staff did not use the biscuit barrel and gave people biscuits from a packet. People were not offered a choice of biscuit or told what type of biscuit they were being given.

Some people were not able to have a bath or shower as often as they liked. During the inspection one person approached the registered manager and asked if they could have their hair washed. They said, "Can I have my hair washed, it has only been washed once since I've been here and it feels awful now". The person told us they usually washed their hair twice a week and had been at the service for nearly three weeks. The registered manager confirmed that the person had only had their hair washed once in that time.

People told us their spiritual needs were not met. They told us the activities coordinator from the service next door used to support them to attend regular religious services but they had not been supported to do this for a long time. People said they missed attending the services. The activities coordinator believed that people were supported to attend church services in the afternoons when they were not working, so had not arranged any at Ashbury Court. The registered manager had not checked that people's spiritual needs were being met and did not know they were no longer attending the services in the next door service.

The provider and registered manager had not taken action to make sure that people were treated with respect at all times and were supported to follow their beliefs. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A hairdresser visited the service weekly and people told us they enjoyed having their hair done. The hair dresser used the hairdressing saloon in the next door service. People told us this had been redecorated and looked nice but they could not see themselves in the mirror. They told us they liked to be able to see their hair during and after it had been done to make sure they liked it. One person said, "It would be good to be able to see what the hair dresser is doing".

Clothing companies visited the service and held 'clothes parties' every three months. The activities coordinator had arranged for two companies to hold parties at the service every six months to increase people's choices. The parties were booked in advance and people and their relatives were informed so they could plan any purchases they wanted to make.

People sold some of the items they made during art and craft sessions. One person was responsible for holding the products and money and sold the items to people and visitors. They told us they were pleased to be able to sell the items without staff support. Other people did not want to sell the items and were happy for one person to do this.

The activities coordinator held regular coffee mornings with drinks and cakes where people discussed the service. They made suggestions about changes and improvements to the service and these were acted on. For example, a new smoking shelter had been provided as people had said that the shelter they shared with staff was too far away for them to walk to.

Staff used people's preferred names and people were relaxed in the company of staff. Staff knew about people's preferences, likes, dislikes and interests. Some people and their families had shared information about their life history with staff to help staff get to know them. Information about some people's backgrounds was available for staff to refer to in people's care records.

People told us staff helped them remain as independent as possible with personal care tasks such as washing and dressing. They told us that staff did not do things for them they were able to do for them self. One person said, "I wash my hands and face and staff help me wash the rest as I can't do it anymore".

People's bedrooms were homely and decorated to their taste. They had been supported to decorate their rooms with personal items they had brought with them, including pictures, ornaments and comfortable chairs.

People told us they had privacy and staff always knocked on their bedroom door before entering. People decided how much privacy they had. Some people preferred to have their bedroom door open when they were in their room and other people chose to have their door closed.

Confidential information about people was held securely. People who needed support to air their views were supported by their families, solicitor or their care manager. No one required the support of an advocate at the time of our inspection. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Inadequate

Is the service responsive?

Our findings

Before moving into Ashbury Court some people and their families had met with staff to complete an assessment of their care needs. The provider's assessment had not been fully completed and some people had not been asked for important information including their social interests.

An assessment of one person's needs had not been completed before they began to use the service. Staff did not know why the person was receiving a service or the support they needed. The person had been referred to the service by their GP for care while they were recovering from an infection. The registered manager had not assessed the person's needs to make sure they could provide the care the person needed. The previous deputy manager told us they did not know the person and would refer to the person's care plan for information about their abilities and support needs. The person's care had not been planned and guidance had not been provided to staff about how to support the person.

Guidance had not been provided to staff about how to provide some people's care and staff did not always know how to support people in their preferred way. One person told us, "The staff member who went to bring me down earlier. She brushed my hair with her hand, I had shingles on my head, you can see the scars. It's damaged the nerve endings and it was so painful when she did that. I didn't want her to, but she wasn't to know". The registered manager confirmed that the person did not like people touching their head, but that this was not written in their care plan. They said, "Why would someone touch [the person's] head?" We told the local authority safeguarding team about this.

Detailed guidance was not provided to support staff to provide consistent care to people in the way they preferred. For example, to ensure staff responded appropriately when people were distressed or anxious and displayed behaviours that could challenge. One person's care plan said, 'Take care, can be aggressive or uncooperative. Puts others at risk'. There was no information for staff on what these behaviours may be and what may cause the person to behave in this way. Staff were advised to, 'Be firm with [the person] and tell them that certain verbal or physical behaviour is not acceptable and ignore their demands until they settle and behave in a manner that is acceptable…Put [the person] in their room safely and check every half an hour to see that they have settled'. The registered manager told us that the person had not agreed to being 'put' in their room. They had decided this was the best way to support them with their behaviour and had not consulted health care professionals for support and guidance.

Staff did not always follow the guidance provided in people's care plans. For example, one person's care plan informed staff the person was 'Able to feed them self at times' and 'Requires encouragement of one carer putting the spoon in their hand, this triggers [person's name] to start to feed themselves. After a while they will tire and require assistance'. We observed staff supporting the person at lunchtime. Staff did not encourage the person to eat their meal without assistance and supported them with their entire meal.

Reviews of people's care had been completed by solely by staff. People and their relatives had not been invited to take part in reviewing and updating their care plans to make sure their views were included. The operations manager had introduced, 'resident of the day' to make sure people were involved in planning

and reviewing their care and this information was available to all staff. The registered manager told us the system did not work in practice and they had not implemented in at Ashbury Court. They had not taken alternative action to make sure that people were fully involved in planning and reviewing their care.

People's care plans had not been changed when their needs changed. One person's care plan instructed staff to weigh the person every week as they were at risk of losing weight. The person had not been weighted weekly during 2016. The registered manager told us the person had put on weight and no longer needed to be weighed each week. Staff had reviewed the person's care plan each month had not noted a change in the support they needed.

The provider and registered manager had failed to carry out with people an assessment of their needs and preferences and had failed to provide person centred care that met people's needs with supporting care plans. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed the activities they took part in at the service. They showed us the Christmas decorations and gift tags they had made and sold to visitors to raise money for further activities. People had made items to sell at a summer fete and were proud of raising £110. One person's relative told us, "The activities co-ordinator is brilliant. There's knitting circles and stuff like that. On a Thursday there is a chap that comes in and sings with them."

On the first day of the inspection people were involved in helping to choose and sort Christmas decorations to be displayed around the service. Everyone sat around a large table and Christmas music was playing. Some people chose to wear tinsel or Christmas themed hats and there was lots of chatter and laughter. On the second day of the inspection people decorated a Christmas tree in the dining room. An entertainer visited the service in the afternoon and sang with people. Some people clapped or swayed in their chair to the music.

An activities coordinator worked during the week and spent time doing activities with individuals or groups of people. An activities plan was in place and was flexible to people's choices each day. The activities coordinator was enthusiastic and encouraged everyone to take part in activities they enjoyed. They supported people to continue doing activities they liked in the afternoons and evening with other staff. People enjoyed activities such as reading, knitting and doing crosswords in the afternoon.

The provider sent ideas for activities to the activities coordinator each month. They used and adapted these ideas into activities offered at Ashbury Court, such as growing seasonal plants. They produced a monthly newsletter for people and visitors including people's achievements and upcoming events. Plans were in place to write activities care plans for everyone to help staff support people do things they liked at the weekends and in the evening.

A process was in place to receive and respond to complaints. Complaints had been received regarding the lift being out of order and the way staff had spoken with a relative. The lift had been repaired and the complaint had been resolved to the person's satisfaction. The registered manager documented any complaints and ensured they were investigated and responded to as necessary.

Inadequate

Is the service well-led?

Our findings

A registered manager was managing the service and knew staff and most people well. They were supported by a deputy manager who had been appointed shortly before our inspection. The previous deputy manager was working at the service next door and also supported the registered manager at Ashbury Court.

Staff told us they generally felt supported by registered manager. One staff member told us, "I feel like I have the support I need. If I have any concerns I go to the registered manager."

Staff had not been made aware of their specific roles and responsibilities. For example, a care plan had not been completed for a person who had moved into the service shortly before our inspection. The registered manager told us it was the responsibility of the senior carer on duty to complete care plans for new people when they were not on duty. They also told us, "I'm not sure I communicated this to the senior carer on the day".

The registered manager instructed a care worker to write the person's care plan during our inspection. We asked the staff member if they knew the person. They told us they did not know them well and had "Not provided much support to them". The registered manager had not checked that the staff had the skills and knowledge they needed to write the person's care plan.

The provider had taken over the service in May 2016. The current and previous providers are owned by the same company Orchard Care who purchased the service in September 2015. Information about Orchard care's philosophy of care and core values was available to people and staff. These included privacy, dignity, rights, independence, choice and fulfilment and meeting people's medical, cultural, psychological, spiritual, emotional and social needs. We found the provider's philosophy of care and core values was not always being provided.

The provider completed quality audits of the service. The last audit was completed in October 2016. This had identified some of the shortfalls in the service we found, such as reduced staffing levels and lack of action to mitigate the risk when one person was assessed as being at risk of malnutrition. However, it had not identified other shortfalls we found and stated medicines records were 'maintained to a high standard' and care plans were comprehensive when we found that they were not. The lack of response to people's weight loss, the lack of an evacuation plan for everyone and poor record keeping had not been picked up by the audits.

The provider had a system of monthly checks and audits in place to check the service was safe. The registered manager had completed these each month but had failed to identify the shortfalls we found. The provider had not identified in their quality audits that the registered manager's checks were ineffective. Staff practice had not been monitored. The registered manager was not aware of the shortfalls in staff practice we found, including poor record keeping and disrespectful behaviour.
People and their families were asked for their views and opinions about the service yearly. A quality assurance survey was sent to people and their relatives. The provider had collated the feedback to look for

patterns and trends and shared this with the registered manager. The results of the survey had been discussed at a recent residents and relatives meeting. On the whole feedback had been positive about staff, however some relatives had raised concerns that their loved ones did not get to go out as often as they would like. The registered manager had told relatives that it was not the provider's policy to take people out and had not taken action to support people to go out to remain part of their community.

Staff had not had regular opportunities to share their views about the quality of the service and make suggestions about changes and developments to the provider. They told us the registered manager listened to their suggestions and acted on them, such as suggestions for new activities. Other stakeholders including district nurses, GP's and other professionals were not surveyed for their views.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including staff and visiting professionals, on the services provided to continually evaluate and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records in respect of each person's care and support had been kept, however they were not accurate and complete. Records did not contain all the information staff and visiting health care professionals needed to assess, review and plan people's care, including what people who were at risk of losing weight had eaten. One staff member told us, "On the first floor, it's big so half an hour is not long enough to write up all the records. There's the GP beds and lots of rooms. We could just do with more time to complete everything you need to".

The registered manager agreed that staff did not have time to complete all the records that the provider required. They also told us the provider required staff to record the same information in different places. One staff member told us, "I think some staff might rush their paperwork. We do try to remind each other but sometimes people forget". The registered manager had not made sure staff had time to record important information, such as the support people had received and changes in their medicines. Staff were not able to provide us with information quickly when we asked for it. There was a risk that information would not be available to visiting health care professionals who may need it when assessing people's needs and planning their care and treatment.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The registered manager had notified us of significant events that had happened at the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider and registered manager had not taken action to make sure that people were treated with respect at all times and were supported to follow their beliefs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. The provider and registered manager had failed to appropriately support and train staff to be competent to fulfil their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had failed to carry out with people an assessment of their needs and preferences and had failed to provide person centred care that met people's needs.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had failed to assess and mitigate risks to people. The provider and registered manager had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. The provider and registered manager had failed to ensure people were safe and had the support they needed to manage their health needs.

The enforcement action we took:

We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including staff and visiting professionals, on the services provided to continually evaluate and improve the service.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We served a warning notice.