MMCG (2) Limited

Ashmead Care Centre

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

People living at Ashmead Care Centre receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate up to 110 people across six self-contained units located over three floors, each with their own separate adapted facilities. The two ground floor units, known as Primrose and Bluebell, specialise in supporting older people with nursing care needs; the three units known as Lavender, Buttercup and Rose support older people living with dementia; and Daffodil is a specialist step-down unit that provides intermediate short-stay support to younger and older adults with a range of personal and health care needs, including physical disabilities, mental ill health and behaviours that might be considered challenging. A step-down unit is traditionally used to provide people with the short-term care and support they need to enable them to return home. At the time of our inspection 109 people resided at the home.

The service has not had a registered manager in post for the past 2 months. In the interim the deputy manager has been in operational day-to-day charge of the service. At the time of our inspection a regional peripatetic manager was appointed as the service's new manager. They have submitted their registered manager application to us. A registered manager is a person who has registered with the CQC. Registered managers like registered providers 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.

In August 2017 the home was re-registered by the CQC after the service was taken over as a going concern by a new provider known as MMCG (Maria Mallaband Care Group). At the last comprehensive inspection of this home in June 2017 when they were owned and managed by Lifestyle Care Management, we rated them 'Requires Improvement' overall. This was because staff record keeping, governance systems and risks associated with people's nutritional needs were not managed well.

At this comprehensive inspection, we found after 12 months in charge the new provider had begun to improve the standard of care and support people living in the home received, but they acknowledge further improvements are required. We have therefore rated Ashmead Care Centre 'Good' for the one key question, 'Is the service caring?' and 'Requires Improvement' overall and for the other four key questions 'Is the service safe, effective, responsive and well-led?'

This was because some staff failed to always correctly follow risk management plans that were in place to keep people safe. Three significant incidents involving people living in the home had occurred in the last 12 months which resulted in people sustaining injuries that could have been avoided if staff had followed their risk management plans.

In addition, staff did not have all the right knowledge and skills to effectively carry out their roles and

responsibilities. Although the new provider had a well-established training programme in place, it did not cover the needs of everyone who lived at the home. For example, staff had not received any training in learning disability or autistic spectrum disorder, mental ill-health or sensory impairment.

Both these shortfalls represent breaches of the Health and Social Care (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Furthermore, people did not always have sufficient opportunities to participate in meaningful activities that reflected their social interests. We discussed this issue with the new managers who acknowledged the range of fulfilling activities people could choose to engage in was limited. We also recommended the provider seek advice and guidance from a reputable source, about developing a programme of social activities that met the needs and social interests of people living with dementia.

We saw the premises were not suitably decorated or adapted to meet the needs of people living with dementia. People living in the home with communication needs could not always access information they needed to make informed decisions and choices about the care and support they received because it was not available in easy to understand pictorial, large print, audio or different language formats.

Finally, although good governance systems to assess and monitor the quality and safety of the care and support people received were in place, we found these were not always operated effectively. During our inspection we identified many issues that the providers governance systems had failed to pick up, such as staff medicines recording errors, poor basic food hygiene practices and outstanding maintenance jobs.

The negative comments described above notwithstanding, most people living in the home, relatives and community health and social care professionals felt the standard of care provided at Ashmead Care Centre had begun to steadily improve since the new providers and managers had been in charge.

There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse and neglect. Appropriate recruitment checks took place before staff were permitted to commence working at the home. The environment was kept hygienically clean and safe. People received their medicines as prescribed.

People were supported to eat and drink enough to meet their dietary needs and preferences. Managers were aware of their duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing any care and support and followed legal requirements when people did not have the capacity to do so. They also received the support they needed to stay healthy and to access health care services.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were nearing the end of their life, they received compassionate and supportive care.

People had an up to date personalised care plan, which set out how their care and support needs should be met by staff. The new manager and his deputy were well-regarded by people living in the home, their relatives, community professionals and staff. The provider had suitable arrangements in place to appropriately deal with people's concerns and complaints.

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

Some aspects of the service were not safe. This was because staff did not always follow risk management plans that were in place to keep people safe from avoidable harm.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

There were enough staff available to meet people's needs. We found that staff recruitment processes helped to ensure suitably fit people worked at the service.

The home was clean and free from odours and there were robust infection control measures in place.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. This was because staff did not have all the right knowledge and skills to effectively carry out their roles and responsibilities.

In addition, the premises were not consistently decorated or adapted to meet the needs of people living with dementia. The provider told us an improvement plan had already been agreed to redecorate and adapt the home's physical environment to make it more dementia friendly.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access health care services.

Managers were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. We observed positive interactions between people living in the home and staff.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. People did not have sufficient opportunities to participate in meaningful activities that reflected their social interests.

Furthermore, although people were encouraged to be involved in discussions about the care and support they received at the home, information was not always available in accessible formats for people with communication needs who had a sensory loss or could not understand English.

People had up to date care plans, which set out how staff should meet their care and support needs. This meant people were supported by staff who knew them well and understood their individual needs, preferences and interests.

The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. Although systems were in place to monitor and review the quality of service delivery; these governance systems were not always effectively operated because they had failed to identify a number of concerns we had found during this inspection.

The service does not have a registered manager in post, although the new manager who is now in day-to-day charge of the service has submitted their application to register with the CQC.

The provider routinely gathered feedback from people living in the care home, their relatives and professional representatives.

Ashmead Care Centre

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 was conducted over two-days on 24 and 30 July 2018. The first day of our inspection was unannounced and we told the provider we would be returning on the second day. The inspection team on the first day consisted of two inspectors, a specialist advisor who was a registered nurse and an expert-by-experience. The expert-by-experience had personal experience of caring for someone who lived with dementia. Only the lead inspector returned to the service on the second day.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke in-person with 15 people who lived at the home, and ten visiting relatives/friends and a continuing care nurse assessor. We also talked with various managers and staff who worked for the provider including, the new manager, the deputy manager, a regional quality and compliance manager, a regional clinical standards manager, the head of human resources, eight registered nurses, 12 health care workers, an activities coordinator and the head chef.

Throughout our inspection we observed the way staff interacted with people living in the home and performed their roles and responsibilities. We also used the Short Observational Framework for Inspection (SOFI) to observe lunchtime meals being served on the units on both days of the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included 16 people's care plans from across all six units, six staff files and a range of other documents that related to the overall management of the service including, quality assurance audits,

medicines administration sheets, complaints records, and accidents and incident reports.

In addition, we received written feedback about the service from two relatives' and three community health and social care professionals including, an NHS continuing care nurse assessor, a social worker and a local authority safeguarding coordinator.

Requires Improvement

Is the service safe?

Our findings

People were not always kept safe at the home because some staff did not always follow risk management plans properly. We received mixed comments from community health and social care professionals who were concerned staff did not always follow their clients risk management plans. One external social care professional told us, "My client suffered a fall due to staff leaving them in the lounge by themselves even though their care plan makes it clear they were at risk of falls and should have had one-to-one staff support in place." Furthermore, we were aware that three people living in the home had sustained injuries in the last 12 months after being involved in incidents that could have been avoided if staff had followed these individuals risk management plans and ensure they received one-to-one staff support.

This failure represents a breach of regulation 12 of the HSCA (Regulated Activities) Regulations 2014.

This breach notwithstanding, we observed several good examples of staff correctly following people's risk management plans. For instance, we saw two staff work in partnership to appropriately use a mobile hoist to transfer a person safely. In addition, people's care plans included up to date and detailed risk management plans to help staff mitigate identified risks. Risks that were routinely assessed included those associated with falls, moving and handling, the use of bedrails, malnutrition and dehydration, choking, tissue viability, behaviours that might challenge the service and social isolation.

People received their medicines as prescribed, although staff did not always follow relevant national guidelines around recording of medicines they had administered to people. During our inspection we identified some medicines that were still available in their monitored dosage blister pack which staff had incorrectly signed for as given. We discussed this anomaly with the managers who immediately investigated the matter and identified a number of staff medicines recording errors. The managers agreed to ensure the member of staff involved was suspended from handling medicines while their competency to manage medicines safely was reassessed and to remind all nursing staff about their managing medicines responsibilities.

These recording errors notwithstanding most medicines administration records (MARs) we looked at had been appropriately maintained by nursing staff. We saw medicines were securely stored in locked medicines trolleys or cupboards in each unit's locked clinical room. People's care plans contained detailed information about their prescribed medicines and how they needed and preferred them to be administered. Our checks of stocks and balances of controlled drugs confirmed these had been given as indicated on people's MAR sheets. In addition, protocols for managing 'as required' medicines were in place and clear instructions were printed on MAR charts so staff knew when and how to administer these types of medicines. Staff received training in the safe management of medicines and their competency to handle medicines safely was routinely assessed.

Appropriate systems were in place to minimise any risks to people's health during food preparation. We saw the kitchen was kept hygienically clean, and catering staff used colour coded chopping boards when preparing different food groups and checked fridge and freezer temperatures daily. The home had recently

been awarded the top food hygiene rating of 5 stars by the food standards agency. Records indicated all staff had completed basic food hygiene training.

However, we found food in one unit's kitchenette had been taken out of its original packing and decanted into tupper-ware containers which were not labelled with an expiry date or properly sealed. We discussed this food hygiene issue with the managers who immediately addressed the matter and agreed to remind all staff about their basic food hygiene responsibilities.

People were protected by the prevention and control of infection. People told us the home always looked clean. A relative said, "It's always nice and clean here and usually smells fine", while a community professional remarked, "Ashmead Care Centre is always very clean." We found the service was free from any unpleasant odours. We observed staff appropriately used personal protective equipment when they were providing people with any personal care. Records indicated all staff had received up to date infection control training and there were clear policies and procedures in place. Staff were knowledgeable about what practices to follow to prevent and control the spread of infection. One member of staff told us, "I have had infection control training and it covered hand-washing, protective equipment and the handling of soiled items", while another member of staff commented, "We always change our gloves and other protective clothing when we provide personal care."

People told us they felt safe living at the home. The provider had robust systems in place to identify report and act on signs or allegations of abuse or neglect. Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. Staff told us the new managers continually encouraged and supported them to speak out if they were ever concerned about staff working practices or behaviour toward people living in the home. One member of staff said, "If I suspected abuse I would inform the nurse in charge and the manager. I know about reporting abuse and the whistleblowing policy."

We looked at documentation where safeguarding alerts had been raised in respect of people living in the home and saw the new provider had taken appropriate steps, which they followed up to ensure similar incidents were prevented from reoccurring. The provider had alerted the local authority's safeguarding adults' team and the CQC without delay about these safeguarding incidents and continued to work closely with the relevant safeguarding authorities to manage them.
The provider's recruitment processes were robust. The provider's human resources department obtained at least two employment references from new staff's previous employers and carried out checks on their criminal records, proof of identify, eligibility to work in the UK, full employment history and explanations for any breaks in employment and health.

Staff were adequately deployed throughout the home. Most people living in the home, visiting relatives and health and social care professionals and staff felt there was usually enough staff working at the home. Typical comments included, "Carers are always visible on the units whenever I visit my clients", "I think you can always do with more staff, but there usually seems to be enough of them about" and "Sometimes there's plenty of staff on duty and sometimes we're short staffed, which can be extremely hard and stressful to cope with." Throughout our two-day inspection we saw care staff were always visible in communal areas, which meant people could alert staff whenever they needed them. We also saw numerous examples of staff responding quickly when people used their call bells or verbally requested assistance to stand or have a drink.

The provider used a dependency tool to calculate the amount of care each person living at the home needed to receive. Managers routinely reviewed staff rotas in response to people's changing needs and

additional staff were arranged as required. Managers gave us a good example of how they had responded to a person's changing needs by arranging for them to have one-to-one staff support during the day to keep this individual and others safe.

The provider had suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency and business plans to help staff deal with such events quickly. We saw fire exit signage conspicuously displayed on doors and walls throughout the premises and fire evacuation ski-pads were available in stairwells to help people with physical disabilities navigate the stairs. People's care plans contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills at the home and received on-going fire safety training. Staff demonstrated a good understanding of their fire safety roles and responsibilities.

The environment was safe. Maintenance records showed environmental health and safety, and equipment checks were routinely undertaken by suitably qualified external contractors in accordance with the manufacturers' guidelines. This included checks in relation to the service's gas safety and electrical installations, portable electrical appliances; fire equipment, including fire extinguishers, fire alarms and sprinklers; heating and ventilation systems; water hygiene and monitoring of water temperatures; passenger lifts; and, the routine servicing of mobility aids, bed rails, call bells, and window restrictors. We also saw radiators were suitably covered throughout the home.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have all the right knowledge and skills to effectively carry out their roles and responsibilities. Although the new provider had introduced a comprehensive rolling programme of training for staff, which most staff had completed, the programme was not designed around the specific care and support needs of everyone who lived at the home. For example, staff had not received the right levels of learning disability and autistic spectrum disorder, mental ill-health and sensory impairment awareness training. This meant staff might not have all the right competencies to effectively perform their roles and responsibilities.

This training shortfall represents a breach of regulation 18 of the HSCA (Regulated Activities) Regulations 2014.

The training shortfall described above notwithstanding, we saw all new staff were required to complete a thorough induction and shadow experienced members of staff before being approved to support people unsupervised. To complete their induction staff had to achieve all the competencies required by the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff spoke positively about the training they received and confirmed they could request further training to deliver effective care and support. One member of staff told us, "I've had moving and handling training, fire drills, infection control, safeguarding, mental capacity act and food hygiene, which is refreshed all the time", while another said, "It's because of the training I have the confidence to care for people."

Staff had sufficient opportunities to review and develop their working practices. The new provider had introduced a rolling programme of regular supervision (one-to-one meetings), competency assessments and annual appraisals where staff were encouraged to reflect on their work practices and identify their training needs. Records indicated staff at all levels routinely attended formal individual meetings with their line manager. Staff told us they were encouraged to talk about any issues or concerns they had about their work. One member of staff said, "I have an appraisal every year and a supervision every few months or so. We talk about if we need more training, anything we aren't happy about, staff morale, if we're happy in our role and if we can think of anything we need to do to improve. We agree a set of goals to achieve by the next supervision."

Most people told us the home was a comfortable place to live. We also saw the premises were kept free of obstacles and hazards which enabled people to move safely and freely around the home. However, we saw signage used to help people orientate themselves and identify important rooms or areas varied between the units. For example, although we saw there were some signs up in the home to help people identify toilets and bathrooms, most bedroom doors lacked any visual clues to help people recognise their rooms. The deputy manager told us memory boxes that would contain photographs and other items that were important to a person had been purchased and would be displayed near the bedroom doors of people living with dementia to help stimulate these individual's long-term memories.

In addition, we noted a bathroom and a toilet door on two different units had missing locks, which could compromise people's privacy and dignity, and the latch on a large window in a communal lounge was damaged, which meant it could not be opened to let in some fresh air on one of the hottest days of the year.

We discussed these premises issues with the managers who advised us the missing locks and damaged window latch would be replaced without delay. They also told us plans to redecorate and adapt the homes physical environment to make it more suitable for people living with dementia had been agreed to be completed by the end of 2018. Progress made by the service to achieve these stated aims will be assessed at their next inspection.

People were supported to maintain their health and well-being. People's care plans set out how staff should be meeting their specific health care needs. Staff carried out regular health checks and maintained daily records of the support people received, including their observations about people's general health. The provider ensured people attended regular health care check-ups with a range of community health care professionals including regular visits by GP's, nurses, dentist's opticians and chiropodists. Staff maintained appropriate records of these health care appointments.

People were supported to eat well-balanced, healthy diets. People said they enjoyed the meals they were offered at the home and typically described the quality and choice of meals as "good". One person told us, "The food is pretty good here", while another person remarked, "The meals are tasty and there's always a decent choice." Meals served during lunch on both days of our inspection looked and smelt appetising. We saw there were enough staff available in the various dining rooms to provide personal support to people who required assistance to eat their meal. We also saw staff routinely offered people drinks during and outside of mealtimes.

People's care plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. We observed staff ensure people who were at risk of choking had their food appropriately cut up or pureed in accordance with their nutritional risk assessments. The head chef told us their catering team routinely prepared a range of soft, pureed and fortified (high calorie) meals for people with specific nutritional needs to eat all mealtimes. Routine weight checks were completed for people at risk of malnutrition or dehydration, which ensured any significant weight loss could be identified quickly and appropriately managed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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. We saw appropriate arrangements were in place to ensure people consented to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. This gave staff the information they needed to understand people's ability to consent to the care and support they received. We saw staff always offered people a choice and respected the decisions they made. For example, during lunch we observed staff ask people to choose what they wanted to eat from the daily menu. We saw if

people had capacity they were encouraged to sign their care plan to indicate they agreed to its content and the care and support they received.

Managers had identified that some people required their liberty to be deprived to keep them safe and free from harm. We saw the service had applied to the local authority for authorisation to deprive people of their liberty and maintained records about the restrictions in place and when the authorisations were due to be reviewed.

Good

Is the service caring?

Our findings

People told us they were happy living at Ashmead Care Centre and were complimentary about the staff who worked there. Typical comments we received included, "Staff are respectful and kind", "The home is wonderful" and "The home is great and the staff are very kind." Feedback we received from community health and social care professional was equally complimentary about the staff. One visiting professionals told us, "Nurses and carers are always professional and approachable. On several occasions I have observed staff providing good levels of care and support to people who live at the home."

Throughout our two-day inspection we observed staff interact with people living in the home in kind and friendly way. For example, staff always greeted people warmly and responded quickly to people's questions and requests for assistance. We also observed staff assist people to eat their meals in a dignified manner, which they achieved by sitting down next to people they were supporting and continually engaging with them.

People's privacy and dignity was respected by staff. People and their relatives told us staff knocked on bedroom doors and asked permission to enter before doing so, which we observed staff do throughout our inspection. A visiting professional remarked, "I've always observed staff treat my clients with dignity and respect."

The service ensured people living in the home maintained positive relationships with people that were important to them. Most relatives told us they were always made to feel welcome at the home by staff and were not aware of any restrictions on visiting times. Staff told us people's guests were encouraged to have a sit-down meal with their family member or friend, as well as celebrate special days, such as birthdays and anniversaries.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. People told us religious leaders representing various denominations of the Christian faith regularly visited the home. Information about people's spiritual needs and ethnicity was included in their care plan. We saw Halal meat was available in the kitchen, which the catering staff cooked and stored separately. Halal refers to what is permissible in Islamic dietary law. The head chef demonstrated a good understanding of the wide range of cultural, ethical and religious dietary needs and wishes of people living in the home, which was reflected in the weekly menus and the meals served each day. For example, the chef knew who had a meat-free diet based on their spiritual needs and wishes and who liked to eat Asian style cuisine.

The provider had up to date equality and diversity policies and procedures in place which made it clear how they expected staff to uphold people's rights and ensure their diverse needs were respected. Records indicated staff had received Equality and diversity awareness training as part of their induction.

Staff encouraged people to maintain their independence. Although most people were dependent on the care and support they received from staff with day-to-day activities and tasks, we observed several good examples of staff helping people do as much for themselves as they were willing and able to. For example,

during lunch people who were unable to use traditional cups and plates had been given specially adapted crockery which enabled them to eat and drink with minimal assistance from staff. Staff could also explain to us what aspects of their care people needed support with, such as partly dressing and washing themselves. Throughout the home we saw handrails and a passenger lift that enabled people to move freely around the communal areas.

Requires Improvement

Is the service responsive?

Our findings

The service did not always support people to take part in social activities relevant to their social interests. Most people living in the home and their relatives told us there were insufficient opportunities for them or their loved ones to participate in meaningful social activities, either in the home or in the wider community. Typical feedback included, "Occasionally I would like to access some fresh air and sit in the garden or go out somewhere interesting, but when I ask the staff they tell me there isn't enough staff available to support me to go out", "My [family member] finds their days so boring here…They just watch television all day because there's nothing else to do. Staff don't seem to have the time or can't be bothered to do any interesting social activities with people", "There's not enough stimulation for people here, intellectually or socially. This is the one thing I'm concerned about at the home." In addition, the results of a satisfaction survey conducted by the new provider in 2018 also indicated most people living in the home and relatives felt social activities was an area that required significant improvement.

Throughout our two-day inspection we saw some staff initiate a few activities in communal lounges including a game of skittles and catch the ball. However, most of the time people were not offered particularly meaningful activities to engage in if they chose. For example, on the second morning of our inspection we observed a large group of people sitting in chairs in a communal lounge for hours at a time with little interaction and stimulation from staff. During this period, we saw a radio and television were both on which made it impossible for anyone to listen to or watch what was playing or being shown, even if they had been interested in doing so. The radio was playing pop music quite loudly and the television was tuned to a shopping channel. Several relatives and members of staff told us the home was short of activities coordinators for some time. One member of staff said, "At the moment we only have one full-time activities coordinator for all the units, which means we have to arrange the activities ourselves sometimes, which isn't easy as we're so busy all the time meeting people's basic personal care needs."

We discussed this issue with the managers who acknowledged the range of meaningful activities people could choose to participate in both in the home and the wider community was limited. The managers told us they were actively trying to recruit more activities coordinators to meet people's social needs and interests. Progress made by the provider to achieve this stated aim will be assessed at the services next inspection. We also recommend the service seek advice and guidance from a reputable source, about developing a more structured and dementia friendly programme of social activities which is based on the interests of people living in the home.

The service helped people to make informed choices about the care and support they received at the home. People's care plans contained detailed information about how people preferred to communicate and made decisions about their care and support. The deputy manager told us the service had an ethnically diverse staff team that reflected the ethnic diversity of people living in the home. This meant staff spoke a range of different languages that matched those spoken by people living in the home. People were also given essential information about the services and facilities which helped them make informed decisions about the care and support they were provided. Several relatives confirmed they had been given a guide to the home which made it clear what services and facilities were available at the Ashmead Care Centre.

However, this information was not always available in accessible formats to meet the communication needs of people with a sensory loss or whose first language was not English. For example, other than the standardised written format, no easy to understand pictorial, foreign language, large print or audio versions of the 'Service users' guide, the complaints procedure or care plans were available for people who might need them. This meant people with a sensory loss or whose first language was not English might not be able to access the essential information contained in these documents described above, which could limit their opportunities to be actively involved in making decisions about the care and support they were provided at the home.

We discussed this with the managers who agreed where appropriate easy to understand and more accessible versions of the 'Service Users' guide, the providers complaints procedure and people's care plans would be developed and made available to people with communication needs. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

People received personalised care and support which was tailored to meet their individual needs. Relatives told us the care their family member received at the home was person centred. We saw people's care plans were written in a person-centred way and contained detailed information about each person's specific needs, abilities, likes and dislikes, and people and places that were important to them. They also included information about how people preferred staff to deliver their
personal care. For example, people's daily routine set out for staff when people liked to wake up, how they wished to be supported with getting washed and dressed and when and where they would like to eat their meals. This gave staff good information about what was important to people so that they could tailor support to meet people's individual needs and wishes.

Care plans were kept up to date. A visiting health care professional told us, "My client's care plans and risk assessments are updated monthly If there is any information missing in a care plan, staff always take this on board and immediately address the issue." We saw people's care plans were regularly reviewed and where changes were identified, people's care plans were updated quickly. Information about any changes was shared with staff through shift handovers and staff meetings.
People were given choices about various aspects of their daily lives. One person told us, "Staff always ask me what I would like to wear every day and eat for my breakfast and lunch, and where I would like to take my meals." We observed staff encourage people to choose the food they ate for their lunch by showing individuals what the two main meal options that were available that day would look like presented on a plate. One member of staff commented, "We always ask people what they would like to eat at mealtimes and for people living with dementia we show them what the meals would look like on the plate to help them choose."

The provider had suitable arrangements in place to respond to people's concerns and formal complaints. Most people living in the home and their visiting relatives or friends said they knew how to make a complaint if they were unhappy with the standard of care and support provided at the home. People confirmed they had been given or seen a copy of the 'Service Users' guide, which contained the new providers complaints procedure. A process was in place for managers to log and investigate any complaints received, which included recording any actions taken to resolve any issues that had been raised.

When people were nearing the end of their life, they received compassionate and supportive care at the home. People's preferences and choices for their end of life care were clearly recorded in their care plan and acted upon. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms in care plans for people who had made this decision. Records showed staff had completed up to date end of life care training. Staff demonstrated a good understanding of how to support people who were nearing the end of

their life and their families. One member of staff told us, "Everyone has an end of life care plan. It includes, whether they would like to be resuscitated, where they want to pass away, any music they would like, who they want with them and what they want to wear." Managers told us they worked closely with GPs and palliative care professionals from a local hospice.

Requires Improvement

Is the service well-led?

Our findings

The new provider had established some good governance systems to assess and monitor the quality and safety of the care and support people using the service received, although we found these measures were not always operated effectively. This was because the provider had failed to identify a number of issues we identified during our inspection, such as poor medicines recording and basic food hygiene practices, gaps in staff training, a lack of opportunities for people to engage in meaningful social activities and outstanding maintenance jobs relating to the homes physical environment.

We discussed these governance issues with the new management team who told us they had an action plan to improve how they monitored the quality and safety of the service people received at the home.

These governance issues notwithstanding, we saw senior managers were responsible for undertaking regular audits and spot checks at the home. For example, the regional quality and compliance manager regularly visited the home and carried out themed audits that focused on a different aspect of service delivery each month, while the regional head of human resources routinely checked staff were recruited safely and in line with the provider's staff employment procedures. An independent contractor was also responsible for monitoring the homes health and safety arrangements.

In addition, the managers and senior staff team based in the home were responsible for carrying out their routine checks which included, care plans and risk assessments, medicines management, infection control and food hygiene, fire safety, complaints and safeguarding incidents and accidents. The governance systems described above were also used to review any accidents, incidents or near misses involving people and develop improvement plans when recurring themes and issues had been found.

The service did not have a registered manager in post, although the deputy manager had been in operational day-to-day charge of the home since May 2018. In addition, during our inspection a regional peripatetic manager was appointed the home's new manager who confirmed they were in the process of applying to the CQC to become registered. The new manager was supported in the day-to-day operation of the service by the deputy manager, a clinical lead nurse and a range of senior nurses and care coordinators. At provider level, support came from regional quality and compliance and clinical standards managers. The new management team demonstrated good awareness of their role and responsibilities about meeting CQC registration requirements and for submitting statutory notifications of incidents to us.

People living in the home, visiting relatives and community professionals and staff working in the home all spoke positively about the leadership style of the 'new' management team and typically described them as being "approachable" and "supportive". Comments we received included, "I've been dealing with the deputy manager a lot in recent months who I've always found to be professional, approachable and helpful", "The new manager makes sure things are done well and is good at monitoring the work we [staff] do" and "He's [manager] really working hard to get to know us. We [staff] can approach him at any time or during the designated time he sets aside once a week."

The culture in the service is open and managers encouraged people to get involved and to share their views and concerns, which are listened to and acted upon to improve the home. People and their relatives said they had sufficient opportunities to share their views with managers about the service they or their loved ones received at the home. The provider used a range of methods to gather the views of people living in the home and their relative's, which included regular meetings and care plan reviews.

The provider valued and listened to the views of staff working in the home. Staff attended regular team meetings where they could contribute their ideas to improve the home. Records of these meetings indicated discussions regularly took place which kept staff up to date about people's changing care and support needs. The deputy manager told us they planned to introduce staff surveys to give staff a voice and involve them in the running of the home. They also said they wanted to have an 'employee of the month' award to acknowledge 'excellence' in the work place.

The provider worked closely with various local authorities and community health and social care professionals. A community social care professional gave us a good example of how a local authority's safeguarding and contracts teams had worked in close partnership with the homes new managers during the last six months to develop and agree an action plan to improve staff training and support. Another social care professional told us, "The homes managers liaise well with us." The deputy manager told us they frequently discussed peoples changing needs, reviewed joint working arrangements and shared best practice ideas with a range of community health and social care professionals who frequently visited the home.

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 The provider did not do all that was reasonably practicable to mitigate risks people using the service might face because staff did not always follow risk management plans. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure staff they employed had received all the appropriate training and professional development they needed to enable them to effectively carry out the duties they were employed to perform. Regulation 18(2) (a)