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Ash-leigh House

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

Summary of findings

Overall summary

This unannounced inspection took place on Wednesday 27 July and Tuesday 02 August 2016.

Ash-leigh House is registered to provide accommodation and support for up to 10 people with mental health difficulties. The home is located within a residential area of Eccles within walking distance of the town centre. There are two lounges, a kitchen/dining room and a conservatory where smoking is permitted. There are 10 single bedrooms, two on the ground floor and eight on the first floor. There is a garden to the rear of the property and a small car park at the front.

We last inspected Ash-leigh House in November 2015 and rated the service as 'Requires Improvement' both overall and in each key question we inspected against. We also identified five regulatory breaches. These related to safe care and treatment (two parts of the regulation), dignity and respect, good governance and staffing.

During this inspection we identified 14 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person centred care, dignity and respect, safe care and treatment (four parts of the regulation), need for consent, safeguarding service users from abuse and improper treatment, good governance (three parts of the regulation), staffing, fit and proper persons employed and requirements as to the display of performance assessments. We also identified a breach of the Care Quality Commission (Registration) Regulations 2009 regarding notification of other incidents. You can see what action we have asked the provider to take at the back of the report.

The home was not clean, with several instances of uncleanliness around the building. The vast majority of our concerns from the last inspection in relation to infection control still remained.

We found that medication arrangements were not safe, with medication not being stored securely, placing people at risk.

We found the service still did not assess and mitigate risk well. We found several instances where risk assessments had not been put in place following incidents at the home.

The service had recruited one member of staff since our previous inspection, however appropriate recruitment checks had not been undertaken.

The home had an induction programme in place for new staff, although we found no evidence that the most recent recruit had been through this process.

We still saw no evidence of staff receiving training in areas specific to mental health services, such as mental health, challenging behavior and de-escalation techniques. We had raised this at the previous inspection. Staff still hadn't undertaken training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty

Safeguards (DoLS). The manager said these courses had proven difficult to source.

We saw some evidence of staff supervision since our last inspection, however the notes from discussions were brief and only covered training completed, with no discussions about people living at the home or if staff had any concerns about their work.

The home did not always work well with other health care professionals such as the bladder and bowel service, when a person had been referred for further advice.

We observed several instances where the dignity and respect of people living at the home was compromised.

Due to some of the widespread failings within the service, we found people did not always benefit from a caring culture.

There were several missed opportunities for interaction, when staff did not to attempt to engage people in conversations about what they may have wanted to do that day.

Each person who lived at the home had their own care plan in place. However we found certain sections within the care plans to be missing, with some not providing sufficient information about people's care and support.

Care and support provided to people was not always person centred or based around their choices and preferences.

At the last inspection we observed no activities taking place. The manager said this was because people did not want to do this, although this wasn't clearly documented. During this inspection, we were told activities would only be funded if it was financially viable for the service.

Similar to the last inspection, we saw no evidence people were involved in the review and updating of their care plans, which were done each month.

We found no improvements had been made to ensure the quality of service was being effectively monitored by both the manager and provider. The manager told us regular checks and audits were done but not documented.

The manager had sent us an action plan from the previous inspection; however we found it to be inaccurate, with re-occurring concerns still present from the last inspection. We also identified five continuing and several additional breaches of the regulations.

We saw no evidence of any recent resident and relative meetings. The manager said they did take place but weren't documented. The feedback from both staff and people living at the home was that they didn't take place regularly.

We found confidential information was not stored securely, with documentation such as care plans and daily notes accessible to anybody in the kitchen or attic areas.

The home had failed to display the ratings from the previous inspection and to also notify us about certain incidents at the home, including a recent fire. Both of these failures are considered to be an offence.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medication was not handled safely.

The home was not clean, presenting the risk of the spread of infections to people.

Risks were not assessed or mitigated well in relation to people's care, support and incidents at the home.

Recruitment of new staff was not safe, with appropriate checks not carried out.

Is the service effective?

Inadequate

The service was not effective.

We found no evidence of an induction for the most recently recruited member of staff.

Staff supervisions were inconsistent and limited in detail. Two members of staff said they weren't regular and couldn't remember their last one. We also found gaps in training from the previous inspection had not been addressed.

People had access to health care services, but the home did not always engage with them well and seek appropriate advice.

Staff had a limited understanding of MCA/DoLS which could place people at risk and we saw evidence of restricted practices.

Is the service caring?

Inadequate

The service was not caring.

People's privacy and dignity was not promoted by staff and was compromised on occasions.

Interactions between staff and people were limited meaning there were missed opportunities to strike up conversations.

Due to some of the wider failings within the service, people did not always benefit from a caring culture.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

We found appropriate care plans were not in place, with some lacking in detail.

Where people had expressed their likes and dislikes, this wasn't always acted upon. For instance in relation to activities and meal choices.

People said they would speak with staff if they had a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

There were no systems in place to monitor the quality of service by either the manager or provider and we found both continuing and additional breaches of regulation. The action plan sent following the last inspection was also inaccurate.

Confidential information was left accessible in the kitchen area such as people's daily notes.

We saw no evidence of recent staff and resident meetings where views and opinions could be obtained.

There had been a failure to notify CQC of incidents which occurred at the home. The ratings from the previous inspection were also not displayed.

Ash-leigh House

Detailed findings

Background to this inspection

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

We carried out this unannounced inspection on Wednesday 27 July and Tuesday 02 August 2016. The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before the inspection we reviewed all of the information we held about the home. This included any concerns or whistleblowing/safeguarding alerts we had received. We also viewed previous inspection reports, to establish any historic concerns with the home.

We also contacted other agencies involved with the home such as Infection Control, Commissioners and Greater Manchester West (GMW). This was to ascertain if they had any information to share with us.

As part of the inspection we spoke with the following people and reviewed the following information:

- Six people who lived at the home.
- Six staff members. This included the proprietor, the registered manager, the deputy manager and three support workers.
- Two relatives
- Six Care Plans
- One staff recruitment record.
- Five medication records

Inadequate

Is the service safe?

Our findings

We asked people living at Ash-leigh House if they felt safe living there. One person told us; "I feel safe living here because I class this as my home and I have lived here for many years". Another person said; "No concerns about my safety here". A visiting relative told us; "I've no concerns. The home is very good for [person] and is very accommodating of their needs. The staff know to ring me day or night and they do".

Two people told us they didn't feel safe living at Ash-leigh House. One person said; "I used to feel very safe living here but not at the minute. This is because another person living here keeps having a go at me for no reason. There is a safeguarding meeting about it all next week". Another person added; "I feel frightened sometimes". We were told safeguarding meetings were scheduled in the coming weeks.

We looked at safeguarding systems at the home. We spoke to staff about their understanding of safeguarding and recognising the potential signs of abuse. One member of staff told us; "Not speaking to somebody correctly could be classed as verbal abuse. I would report my concerns to the manager". Another member of staff said; "The main thing is to prevent abuse and put systems in place to ensure people are safe. Physical, verbal, sexual and financial are all types of abuse that can occur. Changes in behaviour, or people becoming depressed or anxious could indicate abuse".

At the last inspection we found the home was not clean and found this time that the vast majority of our concerns in relation to infection control still remained. We observed one upstairs toilet had been left heavily soiled for approximately 12 hours on the first day of our inspection, despite the manager telling us staff cleaned it daily. We also observed several instances of uncleanliness around the building which included dirty bedrooms, walls, chairs and a dirty staircase. We saw skirting boards around the home had grime and dirt on them. There was also a porridge stain at the top of the stairs which was there at the last inspection. The manager said this had proven difficult to remove. The carpet itself was old and needed replacing, however we were told this wouldn't be financed by the provider.

We observed two bathrooms didn't contain paper towels so that people couldn't wash their hands after going to the toilet. These still hadn't been replenished when we returned for the second day of the inspection. The manager said these were on order, but hadn't yet been delivered with no additional supplies held in the home. We saw hand hygiene guidance had been introduced since our last inspection in toilets; however this was just a picture of a tap and hands and was not informative about how to safely reduce the spread of infections. We were told the home had recently employed a cleaner at weekends, however cleaning during the week was expected to be done by staff. The manager said she monitored the cleaning carried out by staff, but didn't fill in appropriate documentation.

We observed staff use the same mop to clean the bathroom floor and then a bedroom floor. The staff member did not have the mop bucket with them so the mop was not cleaned between surfaces. This meant that dirt from the bathroom would have been mopped across the person's bedroom floor. This did not comply with IPC (Infection Prevention Control) guidance where a separate mop should be used to clean bathrooms, kitchens and bedrooms. These issues meant there had been a breach of Regulation 12 (2) (h) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safe Care and Treatment. This was because the home were not assessing, preventing, detecting and controlling the spread of infections.

We looked at how medication was handled. On the first day of our inspection, we saw medication was left on tables in the kitchen and in boxes in a small room between the kitchen and lounge area. This was whilst people were present in the kitchen area. We observed the manager and deputy manager moving these boxes. We later found they had been moved into the basement; however the door was left unlocked until we alerted staff. This meant people could potentially access medicines in an unsafe manner, placing them at risk.

During the inspection we looked at five MAR (Medication Administration Record) charts. At the last inspection, we raised a concern that MAR charts did not have people's photographs on them. This would reduce the risk of staff giving medicine to the wrong person and make it easier to identify people living at the home. This concern still hadn't been addressed at this inspection. The manager said the pharmacy was doing this and had made comment that the photographs provided were not suitable.

The MAR charts were non-specific for the times medicines should be administered and indicated general times of morning, lunch, teatime and bedtime. This meant the service could not be sure there was an adequate time gap between doses. Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, we saw that individual 'when required' protocols were in place.

Staff were unable to identify the medicines, which were required to be administered before or after food and did not clarify with people if they'd eaten or not prior to administering these medicines. We saw one person who had been prescribed a medicine that required strict adherence to the guidance. For example, if the person missed this medicine for a 48 hour period, a doctor would need to be consulted as to whether the medication required re-starting. There were no protocols with the MAR chart or in the person's care file to inform staff of this requirement. We directly asked staff to ascertain their understanding of the requirements and they were unaware that this medicine was any different to other medicines, or the safety precautions to follow if not taken as directed.. Two staff members told us that if this person had missed their medicines for over 48 hours, they would not have known to seek medical advice and would have given the person their medicines.

On the second day of the inspection we found three tablets between the laminate floor and concrete fire. We noted that one of these tablets was the person's tablet that required strict adherence with administration protocols. We showed staff that the medicine was there and they acknowledged that they did not know how long it had been there for. These issues meant there had been a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safe Care and Treatment. This was because appropriate systems were not in place with regards to the the proper and safe management of medicines.

At the last inspection we found the home did not assess and mitigate risk well and found further concerns during this visit. We found several instances where risk assessments had not been put in place following incidents at the home. For example, in advance of the inspection, we were made aware of an incident where a fire was started in a bin, with the perpetrator being sectioned as a result and the fire brigade being called to the home. We saw no evidence of a risk assessment being completed, to inform staff of how to manage this risk and prevent a re-occurrence of the incident.

We saw from looking at accident records that one person had fallen five times, although hadn't suffered any serious injuries. Despite this, a falls risk assessment had not been implemented which would inform staff about how to keep this person safe and monitor their mobility. We also saw in two care plans that people smoked in their bedrooms, however staff relied on these people handing in their cigarettes and lighters before returning to their bedrooms. Additionally, there were no risk assessments in place to demonstrate how this potential fire risk was being managed. We saw some risk assessments in people's care plans, which had been created following our previous inspection concerns in November 2015; however there was no evidence these had been reviewed since then, to ensure this information was still accurate. The manager told us they had risk assessed these areas, but had failed to write any of it down.

These issues meant there had been a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safe Care and Treatment. This was because the home were not doing all that was possible to mitigate such risks.

Since our previous inspection in November 2015, the home had recruited one new member of staff, who was a domestic. Apart from seeing a completed application form, we saw no evidence of any other recruitment checks being undertaken such as an interview, seeking appropriate references, or ensuring a DBS (Disclosure Barring Service) check was in place. The manager said a DBS had been applied for but hadn't yet been returned. The manager said this person only worked at weekends and would therefore be supervised at all times. However, when speaking with a member of staff who had recently worked at weekends, we were told this was not the case, due to there only being one member of staff in the building.

This meant there had been a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Fit and Proper Persons. This was because recruitment procedures were not operated effectively.

We checked to see if there was sufficient staff working at the home to meet people's needs. On the first day of our inspection we arrived at the home at 7am. On the second day we arrived at 6am. We found two members of staff had been on the night shift on both days. Similarly, there were two members of staff working at the home during the day. This was to provide care and support to 10 people.

We found there were sufficient numbers of staff working at the home during the week, but we saw they were not effectively deployed to meet people's needs. We observed staff spent long periods of time sat in the kitchen, which meant they were not proactively supporting people. We saw there was only one member of staff working at the weekend which meant they would be unable to support people in the community if required or if an emergency situation arose. The manager said she lived close by and was available to come into the home at weekends if required . The home did not use a formal dependency tool to determine how many staff was required to look after people safely. The manager said staffing numbers were devised around budgets.

We asked staff for their views about current staffing levels. One member of staff said; "I've spoke to the manager about weekend staffing levels and they have said they are looking into it. In terms of providing care and support to people it's ok, but if somebody was injured or something happened it would be hard on my own. Nothing has happened yet that I can recall". Another member of staff said; "I always work nights here. I would say I manage okay at night. If people are ill in the night it can be a struggle, but people have been okay of late. We are okay at the minute I feel".

We saw that in three upstairs bedrooms, window restrictors were in place, but could be altered to make the windows open wider. Staff said people had chosen to open the windows wider due to the warmer weather

during the inspection. This increased the risk of people being able to climb out of the window and potentially fall, however we were confident these people had the capacity to understand the risk this presented. We raised this issue with the manager who alerted the handy man straight away. However when we returned for the second day of the inspection, the windows were wide open again. We received written confirmation from the proprietor the following day stating this concern had now been rectified.

Inadequate

Is the service effective?

Our findings

The home had a staff induction programme in place, which new staff were expected to undertake when they first started working at the home. This covered areas such as familiarisation with the building, safety procedures, confidentiality, fire procedures, accident reporting procedures and working hours. Since the last inspection, the home had recruited one new member of staff who worked at weekends, however we were unable to see that this person had undertaken the induction as was required. One member of staff said; "The new starter has been here a couple of weeks, but they just seemed to come and get on with it straight away rather than doing an actual induction".

At the last inspection we raised concerns about a lack of training for staff in certain areas. At this inspection, we still saw no evidence of staff receiving training in areas specific to mental health services, such as mental health awareness, challenging behaviour and de-escalation techniques. We also found that staff still hadn't undertaken training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards . The manager said these had proven difficult to source. The home's training matrix showed staff had undertaken training in areas such as medication, infection control, health and safety and first aid. However there were no dates of when refresher training would be due, making it easier for the manager to monitor. One member of staff said; "I would say there is enough training, however updates aren't that regular". Another member of staff said; "I covered quite a bit at induction, but haven't been provided with any recent updates since then".

We saw some evidence of staff supervision since our last inspection, however the notes from discussions were brief and only covered training completed, with no discussions about people living at the home or if staff had any concerns about their work. One member of staff told us that supervisions would sometimes just be a 'discussion across the dinner table'. This meant staff weren't being given the opportunity to talk about their work in a confidential setting. When asked about supervision, one member of staff said; "I can't remember the last one". Another member of staff said; "I've had one with the manager in the past, but I think my last one was in 2015".

Due to the issues arising with regards to induction, training and supervision, this meant there had been a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Staffing. This was because staff did not receive such appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform.

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 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. On arrival at the home at 7am, we noted that the front door was unlocked. The staff member told us that nobody living at the home was subject to DoLS. We confirmed that nobody living at the home was under continuous supervision and control and not free to leave.

We spoke with care staff to ascertain their understanding of the MCA. We found that staff did not have sufficient working knowledge of this legislation or its practical application when providing care and support. This meant we could not be satisfied that the care and support being delivered to people who used the service, was always done so by staff who understood the principles of the MCA and acted in accordance with it. We found people were put at risk of having their rights and liberties restricted unlawfully because the staff could not demonstrate they were following legislation around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

For example, we saw a person's cigarettes had been taken from them for smoking in their bedroom, but we found there had been no exploration as to whether the person had the capacity to understood the risks posed. We saw a person's clothes had been removed from their bedroom and when we asked staff about this, they told us that the person had consented to this. There was no documentation or care plans to support best interest decision making and when we asked the person whether they would like their clothes in their bedroom they asked us whether we could sort that out for them. This implied that the person was being restricted and was not having their wishes considered. People's capacity to consent had been not been assessed and recorded, including the level of their capacity to make different decisions.

We saw staff did not always ask for people's consent before carrying out care. For example, a person was in the bathroom and a member of staff went in to the bathroom and started assisting them. They did not ask the person's consent prior to doing this. This was a breach of Regulation 11 and 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to the need for consent and safeguarding service users from abuse and improper treatment.

We looked at how people were supported to maintain good nutrition and hydration. We noted that two people living at the home were on food and fluid charts, which had been implemented following weight loss and an admission to hospital. We found that although the home did weigh people, the information was not consistently recorded in one place to demonstrate that the registered manager had oversight as to whether people were losing or gaining weight. We found it was difficult to illicit this information and to ascertain from the care records what proactive support was offered in these circumstances. A relative of one of the people living at Ashleigh told us; "(Person) did lose a lot of weight but as a family we hadn't noticed and when we did, we put it down to stresses they had at that time. The home got [person] to the GP to be checked out".

During the inspection we observed people preparing their own food and drink independently. For example, we observed one person coming into the kitchen and making themselves a bowl of porridge in the microwave. Another person came into the kitchen and made themselves a cup of tea.

We asked people for their opinions about the food at the home. One person told us; "I like pizza, rice and fish which we do get sometimes. We make our own breakfast and dinner which is usually cornflakes and then sandwiches". Another person said; "We get enough to eat. I give five stars for food. We have spaghetti bolognaise, fish and chips, bangers and mash, roast dinner. There are always bananas, apples and fruity yogurts for a snack".

On the first day of the inspection, it was unclear how the service supported people to attend appointments

with external healthcare professionals such as GPs, dentists, podiatrists and opticians, as care records were not updated to reflect this information. We returned to the home for a second visit to ascertain whether people had appropriate access to healthcare and if the home was making timely referrals.

At our second visit, we found the home had an appointment diary and records showed that people had access to other health professionals. We also saw during our visit that a person who was in pain was made a GP appointment and accompanied to the appointment that day.

However records regarding people's health care were mixed. We saw that one person had been referred to the bowel and bladder service but when we spoke to the service, we ascertained that the home had not engaged in the assessment process. This meant that this person had not been assessed and offered the necessary support to manage their need. We also saw a further two people who had not been referred and would benefit from the support of this service. Staff said that on occasions, these people struggled with their continence management. Staff at the home told us this would be done immediately. This issue had been taken forward by the local safeguarding authority following our inspection and subsequently substantiated. One person did tell us however; "They make appointments for me to see the GP. I've seen the dentist and had my eyes tested".

This meant there had been a breach Regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Safe Care and Treatment.

Inadequate

Is the service caring?

Our findings

We asked people living at Ash-leigh House what it was like to live there and if they received good care. One person said; "It's not too bad and I have been stable now for about five years. Since living here, I've got back on the right track. The care and support is not too bad. Most of the time the staff are kind and caring". Another person said; "I've been here a long time. I'm used to it and I like it. The staff are alright. I like them a lot". A third person also told us; "I'm quite happy living here. They look after me well and support me". Other comments from people living at Ash-leigh House included; "I think staff are nice" and "The staff are okay".

We saw that there were widespread shortfalls in the service, which meant people's immediate needs and their on-going wellbeing did not benefit from a caring culture. Whilst staff had good intentions, they were not supported by the overall management of the service to ensure that people were consistently treated with kindness, compassion and respect. For example, how people's incontinence was managed, the general cleanliness of the home and people's preferences not always being respected. We observed that staff often spoke about people in a task focused manner which was disrespectful and lacked empathy for the person or their situation. For example, one staff member shouted to tell another person living at the home that the fire alarm had been activated due to the smell in the bedroom of a person living at the home.

The language used to describe people's needs when speaking with staff did not reflect a caring, kind and respectful attitude. For example, one staff member stated; "There is no reason for the person to do this medically, it's all behaviour." (when describing a person's incontinence episodes).

During the inspection, we saw some pleasant interactions between staff and people living at the home, however these were only seen when people came into the dining room where staff congregated. On one occasion a member of staff greeted a person by saying; "Hello, it's good to see you my friend". On other occasions, we saw staff remained seated in the dining room, even though between two and three people were sitting in the lounge unstimulated. This was a missed opportunity to strike up conversations and hold discussions about what people potentially wanted to do that day. We raised this issue with the proprietor who felt this was down to 'laziness' of the staff.

We asked people living at the home if they felt treated with dignity and respect by staff. We also asked staff how they aimed to do this when delivering care. One person told us; "They knock on my door before coming in and am offered a towel when I get out the shower so I am covered". Another person said; "The staff are respectful and I appreciate good manners". A member of staff told us; "I'll close curtains to give people privacy and close doors". Another member of staff said; "I'll try and refer to people by their first name. One person has a habit of walking around in their underwear, so I'll try and discourage that".

At our previous inspection, we raised concerns that people were not always treated with dignity and respect by staff. For example, discussing people's illnesses in the dining room when other people were present, as well as staff not being aware when people were not dressed appropriately. At this inspection, we again saw instances where people's privacy and dignity was compromised. For instance, one person was supported whilst on the toilet by a member of staff with the door wide open. The same person was also seen walking

around the home in their underwear, with staff not attempting to discourage this behaviour in a timely manner. Both staff working at the home during the night on the day of our inspection were also male, meaning people wouldn't have the choice of receiving assistance from either a male or female carer for personal care tasks.

We also observed that several people, who had taken themselves to the toilet independently, left the door wide open whilst doing so. Again, we observed there were no staff present upstairs to try and discourage this and promote people's privacy and dignity. One person living at the home said; "I've spoken to the manager in the past about people always leaving toilet doors wide open, because it's not nice for people to see. Nothing gets done about it though".

This meant there had been a breach Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Dignity and Respect.

We asked people living at the home if they felt their independence was promoted. We also asked staff how they aimed to do this when delivering care. During the inspection we observed people making their own meals, mopping kitchen floors and accessing the local community when they wanted to. One person said; "I'm encouraged to go out and meet my friends as well as doing some cleaning". Another person said; "They encourage me to do things such as making my own meals". A member of staff also added; "If people can do their own things then I'll encourage them, but be there to step in if needed".

As at the previous inspection, we did not see evidence within care plans that either people who used the service or their relatives, had involvement in their care planning or completion of reviews. Three people living at the home said they had not seen their care plan recently.

There was an advocacy service in place. An advocacy service helps people to access information they need or provide support to attend meetings or interviews. Advocates can also write letters on people's behalf, or speak to people in situations where the person does not feel able to do so themselves. We noted there was a poster with contact details on the wall in the home.

Requires Improvement

Is the service responsive?

Our findings

We asked people living at Ash-leigh House if they felt the home were responsive to their needs. One person said; "I've had problems with my feet in the past and the staff have taken me to the podiatrist". Another person said; "I get everything I need here. The staff help me with my laundry. The staff come with me if I need to go to any appointments. If it's raining we sometimes get a taxi".

We saw several examples of where the home had been responsive to people's needs. For instance, on the second day of the inspection, a person was limping because they said they had fallen from bed. Staff had noticed this and immediately phoned the doctor to make an appointment for that morning. Another person, who required the medication clozapine, was supported to attend the doctors to have blood tests which was a requirement. Another person had been referred to the doctor due to having some weight loss.

Each person living at the home was able to go out into the community if they wanted, although some chose not to. One person told us about their daily routine and how they enjoyed going out at 8am each morning and not returning until 4pm. This person told us they liked walking and going to Morrison's for their breakfast every morning. Another person said they liked watching sports and we saw this person watching Sky Sports in their bedroom. Since the previous inspection, the home had sought information about people's personal preferences. For instance, what time they liked to get up in the morning, how many pillows they liked in their bed and what their favourite choices of food were. However we saw that all of this information was stored in care plans held in the attic meaning staff didn't have this information at their disposal if they needed it. One member of staff said they hadn't read people's care plans for 'quite a while', due to where they were located.

Despite this, we saw several examples of were care and support provided by staff was not person centred. For example, we observed one person being supported to get dressed in the morning. Their clothes were stored in the basement. The member of staff assisting told this person they would have to 'wait' before putting them on, as they weren't allowed to do this on their own. This person was also given trousers to wear when they expressed a preference to wear a skirt. This person also said staff went shopping for their clothes, but weren't invited to go with them to make choices.

On the second day of the inspection, we arrived at the home at approximately 6am. At this time, there was a note on the notice boards saying that everybody was having an evening meal of quiche, potatoes and salad/coleslaw. On the first day of the inspection, the same meal was also served to people. We saw this was on a plate, wrapped in cling film and given to people as they came into the dining room. We saw there was no consultation about portion size, who would like what, and whether there was an alternative option. One person told us; "I'm not asked what I would like to eat. I don't know what is for tea until I come down for it".

At the previous inspection, we raised concerns about specific care plans not being in place and also lacking important information about people's care and support. We saw little improvement in this area during this inspection. For example, one person's mental health care plan stated their mental health had not been good in the past month and that agitation was evident in their behaviour. Another person's care plan stated

they had been quite unwell of late and had been confrontational with other people living at the home. Another person was reported to have had several episodes of incontinence and several falls. Despite these incidents taking place at the home, we found appropriate care plans were not in place, to inform staff about how to meet the care needs of these people.

We also found there was an inconsistency regarding what care plans were in place. For example, some people had care plans for activities, eating/drinking and medication. However this was not consistent in all the care plans we looked at. We saw people had access to services such as the dentist, however there was limited information in care plans about the support people needed each day, or if they were independent in a particular area. This meant it was difficult to determine what people's care and support needs were.

People were not being protected from the risks of social isolation and loneliness. Staff did not support people with individual interests or hobbies. We were party to conversations in the home that gave us concerns that the culture in the home was institutionalised. For example, according to the registered manager individuals only had the opportunity to engage in organised group activities if eight or more people took part. We observed that people who stayed in their bedrooms did not receive regular interaction from staff, nor were they engaged in activity. One person told us; "I'd say they have been promising more activities for us since about January, but so far nothing". Another person said; "They don't seem to do them anymore. There isn't a lot to do unless I go out".

Due to appropriate care plans not being in place, person centred care not always being provided and activities not being provided, this meant there had been a breach Regulation 9 (1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Person Centred Care.

A satisfaction survey had been sent to people in April 2016. This asked people about the comfort of their bedroom, quality of care received, friendliness of staff, cleanliness of the home, choice of meals provided, decoration/atmosphere, laundry services and overall impressions of the home. We looked at a sample of these and found the vast majority of the comments made were positive about the service they received.

The home had a complaints procedure in place. This was displayed on the wall near the lounge area and informed people who they could make a complaint to and what the contact details were. The manager told us there had been no recent complaints made. The people we spoke with said they would speak with staff if they were unhappy with any aspect of the service.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We received mixed responses from staff when we asked about leadership at the home. One member of staff said; "I don't find the home to be well-led. I don't like the way the manager is with the residents. I would rather speak with the deputy manager who seems to show more concern". Another member of staff said; "On a personal level the manager is personable and caring. However we have seen the feedback during the inspection which shows things aren't right". A third member of staff said; "I can't exactly say the manager is on top of things based on what is being found".

At our last inspection, we identified five breaches of regulations with regards to safe care and treatment (two parts), dignity and respect, good governance and staffing. We found each of these breaches to be continuing during this inspection. We also found additional breaches in areas such as person centred care, fit and proper persons employed, need for consent, safeguarding service user from abuse and improper treatment, displaying performance ratings and notification of incidents.

At the previous inspection we had concerns that quality assurance systems were not in place to effectively monitor the quality of service. We saw no improvements in this area during this inspection. For instance, there were no audits completed in areas such as care plans, medication, cleanliness and infection control, staff recruitment, staff training and staff supervision. These were some of the areas where we had identified concerns during this inspection. We also saw no documentary evidence of medication competency assessments being done, to ensure staff did this safely. The manager told us they did these checks but didn't document anything to show what had been looked at. We were also informed that no provider audits took place, which would potentially identify any failings within the service that were not picked up by the manager.

We asked the manager if they undertook 'walk arounds' of the building to ensure high standards were maintained and that the building was safe and in good condition for people living at the home. The manager told us they did these but again didn't document anything. However, we had concerns these were not being done due to our observations of the cleanliness of toilets, faulty window restrictors, medication being found on the floor and left accessible in the kitchen and lounge areas.

We looked to see how the home managed people's finances and we saw a system was in place for ensuring people's money was managed safely. We checked all of the records and found that the amount of money the home held for the person tallied with the records. However, there was no auditing system in place. This meant if there were financial discrepancies they would not be identified and rectified.

Following the previous inspection the manager sent us an action plan detailing how they intended to make

improvements within the home. The action plan stated various things that would be introduced. These included ensuring people's changing needs were updated in care plans, holding monthly staff meetings, seeking regular feedback from people living at the home, conducting monthly quality assurance audits and completing cleaning rotas to show work completed and areas cleaned. Based on our findings during the inspection, these had not been implemented to improve the quality of service being provided.

At the end of our first day of inspection on 27 July, we provided feedback to the manager about our findings. The manager told us they would immediately address issues such as the lack of paper towels in bathroom areas and the problems with the window restrictors. However when we returned to the home on 2 August, six days later, these issues still hadn't been rectified. The manager wasn't present on the second day of the inspection; however the deputy said the handyman had been round the home and should have looked at these.

These issues meant there had been a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance. This was because the home did not have effective systems to assess, monitor and improve the quality and safety of the services provided.

We found confidential information was not stored securely. For example, people's daily notes containing discussions and conversations about their care were left in files on a shelf in the kitchen area. People's care plans were also stored in the attic, however the door wasn't locked and there was no staff presence in this area meaning anybody could access this information, for example maintenance workers and visiting relatives who were at the home during the inspection.

These issues meant there had been a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance. This was because records were not stored securely with regards to the management of the regulated activity.

At the last inspection, we raised concerns about a lack of staff and residents meetings taking place at the home. The manager said these took place but that the meeting minutes were stored on a computer which had been sent away to be fixed. On its return, we were told these would be sent to us to demonstrate they took place and what the discussions had been. At this inspection, we still found no evidence of these meetings taking place and the home was still without a computer. This meant it was difficult to see how management were seeking and acting on feedback to improve the quality of service. One member of staff told us; "I can't tell you when the last staff meeting was to be honest". Another member of staff said; "I recall one from last year, but certainly nothing recently". A person living at the home also added; "I've mentioned before about people always leaving toilet doors open, but nothing has changed".

This meant there had been a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Good Governance. This was because the home did not appropriately seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity.

Services such as Ash-leigh House are legally required to submit notifications to CQC about significant events such as any serious injuries, safeguarding or events involving the police. We found evidence that the provider had not submitted notifications to us as required in relation to a fire at the home which the fire brigade attended. The manager seemed to be unaware this needed to be done. We are dealing with this matter outside the formal inspection process.

This meant there had been a breach of Regulation 18 of the Care Quality Commission (Registration)

Regulations 2009 with regards to Notification of Incidents.

As of April 2015, it is a legal requirement to display performance ratings from previous inspections conducted by CQC. We found the ratings were not displayed anywhere in the building, or on any relevant websites belonging to the home. Both the manager and provider seemed unaware this was a requirement.

This meant there had been a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to Displaying Performance Assessments.