Ashwood Nursing Home Limited

Ashwood Nursing Home - Etchingham

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We inspected Ashwood Nursing Home on 6 and 10 March 2015. The inspection was unannounced. Ashwood Nursing Home is registered for 19 people. There were 9 people living at the home when we inspected. People cared for were all older people. They were living with a range of complex needs, including diabetes, stroke and heart conditions. Many people needed support with their personal care, eating and drinking and mobility needs. Some people were also living with dementia. The manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Ashwood Nursing home is a large house, which has been extended. There was a lounge dining room on the ground floor. Bedrooms were provided on both the ground and first floor. There was a passenger lift between the floors.

Summary of findings

There was a main bathroom and other toilets available for people to use where bedrooms were not ensuite. There was a garden to one side and back of the home. At least one of the unoccupied bedrooms on the first floor was being used for staff accommodation

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

The home was last inspected on 6 August 2014. At that inspection, we found the home had not met essential standards relating to safety and suitability of the premises, recruitment of staff, staffing numbers and records. We asked the provider to make improvements. An action plan was received which stated the provider would be meeting the regulations by January 2015. At this inspection, although some improvements had been made, people remained at significant risk. This was because we identified a number of areas of practice which potentially placed people at risk of receiving inappropriate care and support. Risks had not been identified through the manager's auditing or quality assurance.

The manager's quality assurance framework was not effective. This meant there was a potential risk across a range of areas, including fire safety, supporting people in moving safely and assessments of appropriate staffing levels at night. Audit processes had also not identified and ensured action was taken to ensure staff were following care plans or updating them if they were no longer what the person needed. Audits had not identified lack of cleanliness and that the home's medicines policy was not being followed in certain areas.

As at the last inspection, issues were identified in relation to record-keeping. We continue to have concerns. Records were not consistently maintained. This included no records of concerns and complaints raised by people and a lack or records where people may show behaviours which needed support. By not having effective record-keeping systems the home was not following guidelines on record keeping by external bodies such as the Nursing and Midwifery Council (NMC).

People's complex needs were not always planned for and delivered effectively. This included the prevention of pressure ulcers, supporting people who were living with dementia and diabetic care and treatment. People's social needs were not assessed and information in their care plans was limited. There was no regular provision of appropriate activities for people.

Medicine management was not consistently safe. We saw a range of errors on the medicines administration records. People's own prescribed skin creams were not being used for them. Systems were not in place to ensure prescribed skin creams were administered in the way intended by the prescriber.

The manager had not followed their own or external guidelines on reporting occasions where a person may have been subject to abuse. Staff had not been trained on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were not aware of their responsibilities in these areas. This included assessment of people's mental capacity, the making of best interests decisions and consideration of whether some aspects of care might be restricting a person's liberty.

Staff did not have the knowledge and skills in a range of areas to ensure they could meet people's needs safely. This included ensuring people were correctly supported to move and meeting the needs of people living with dementia. Action had not been taken to appropriately support staff whose first language was not English.

Staff did not always show a caring approach to people and ensure their dignity was respected. This included when they responded to people living with dementia, ensuring privacy in their rooms was respected and supporting them in making choices about meals. People who were living with a disability did not always have the support they needed to eat independently.

Improvements had been made in relation to recruitment of staff, but some areas still needed to be addressed. This included ensuring all staff had two references on file and evidence staff were appropriately supervised on commencement into their role.

We received mixed responses to how people fedback on the quality of the service. Some people were not clear on feedback systems. Other people said the manager was approachable and always ready to receive feedback.

Summary of findings

A maintenance log had been set up since the last inspection. This was being used by staff to identify areas for attention. People commented particularly on the improvements in the home environment. Systems were in place in relation to other maintenance, such as checks on hot water temperatures and fire extinguisher servicing.

The registered nurse who gave out medicines did this in a safe way. They supported people throughout the time they were taking their medicines and promptly signed for the medicines they gave out.

People were positive about the meals. Meals were attractively presented and people ate them with obvious enjoyment.

People and staff reported there were enough staff on day duty to meet their needs. This included enough staff to ensure a prompt response time when people used their call bell.

Some staff offered people choice, for example about what they wanted to drink and if they wanted to go into the garden. They explained carefully to people how they were going to support them and all staff were consistently polite and kindly when they did talk to people. Staff ensured people's privacy at certain times, such as when they were using the toilet.

Staff told us they felt the whole staff team was supportive of each other. They gave us positive comments about the manager and said they listened to them and took action when they raised issues.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected against potential risks relating to fire safety and moving and handling. Where people may have sustained harm or been subject to neglect, the local safeguarding team had not been informed. The systems for ensuring people were administered their medicines were not safe.

Not all previous shortfalls regarding recruitment had been addressed.

People felt there were sufficient staff on day duty to meet people's needs however, assessments had not been made about the safety of staffing levels at night.

Inadequate

Is the service effective?
The service was not consistently effective.

Staff did not have the knowledge and skills to provide effective care. There was a lack of mental capacity assessments, best interests' decisions and consideration of the Deprivation of Liberties Safeguards where people lacked capacity.

However, some health care needs were supported effectively. People commented favourably on the meals and staff provided frailer people with the support they needed to eat and drink.

Inadequate

Is the service caring?
The service was not consistently caring.

Some people were not involved in relevant decisions about how their needs were met. People's privacy and dignity was not consistently supported. Some systems in the home did not ensure people were involved in choices about their care.

In other areas staff were caring and people were involved in making decisions about their care. We saw some staff were kind and gentle with people, supporting them in an approachable manner.

Inadequate

Is the service responsive?
The service was not responsive.

People's needs were not consistently responded to when delivering care or in care plans to meet their individual care and support needs. This included people's needs for activities, as well as complex nursing and treatment needs.

Some people felt they were not always listened to if they raised complaints. Issues raised by people were not documented so the manager could not ensure matters had been consistently addressed to people's satisfaction.

Inadequate

Is the service well-led?
The service was not well-led

Inadequate

Summary of findings

The manager's systems for quality audits did not identify all relevant areas so action was not taken to address them. The manager did not ensure the staff followed relevant guidelines. Relevant records were not being completed in all cases.

The systems for feedback from people were variable.

Several people and staff commented favourably on the manager. Many staff commented positively on the culture of the home.

Ashwood Nursing Home - Etchingham

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. On 1 April 2015 the Care Act 2014 came into force. To accommodate the introduction of this new Legislation there is a short transition period. Therefore within this inspection report two sets of Regulations are referred to. These are, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All new inspections will only be completed against the new Regulations - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited the Ashwood Nursing Home on 6 March 2015 and 10 March 2015. This was an unannounced inspection. The inspection team consisted of two inspectors.

During the inspection, we spoke with the nine people who lived at the home, eight visiting relatives, five care workers, the registered nurse, the cook, the administrator, members of the manager's family and the manager.

Before our inspection we reviewed the information we held about the home. We contacted the local authority to obtain their views about the care provided. We considered information which had been shared with us by the local authority, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We looked at areas of the building, including people's bedrooms, communal areas, a bathroom, the medicines room and laundry/sluice room. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We made observations of how people were, and support they received from staff throughout the inspection. We also observed a lunchtime meal and a medicines administration round.

We 'pathway tracked' five people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed the records of the home. These included 17 staff training records, three staff recruitment files, medicines records, risk assessments and policies and procedures.

Inadequate

Is the service safe?

Our findings

People said they felt safe in the home. One person told us "I'm perfectly safe, people see that I'm all right," another person reported "Safety's the important thing, I wasn't safe at home, I am here." A relative told us if they were unable to visit for a while, they would not be worried about their loved one's safety. Although people told us they felt safe, we found examples of care practice which were not safe.

At the last inspection on 6 August 2014, we found there were risks in the environment which meant that people, staff and visitors were not protected against the risks of unsafe or unsuitable premises. The provider sent us an action plan on 7 October 2014, in which they reported on areas which had been addressed, and areas which would be addressed by January 2015. At this inspection we found while the provider had addressed areas outlined in the previous inspection report, they had not identified and taken action on other significant areas to ensure people were living in a safe environment.

People were not always protected from avoidable harm. All people had fire doors on their bedrooms to protect them in the event of fire. Where people wanted their door to be held open, the home used devises which had been approved by the fire authority to do this. These devices ensure doors close in the event of a fire alarm, to protect people from fire and the risk of smoke inhalation. Three people who remained in their rooms had additional objects, also holding the door open, including a chair or a cloth. This meant in the event of a fire, the doors would not close to protect these people from the fire or the effect of smoke inhalation. The use of additional objects to hold doors open also meant the batteries in the devices may be affected, so they may not function effectively in the event of a fire. We asked staff why they were using additional objects to hold doors open. They reported the devices did not always function and hold doors open. We also saw the door between the kitchen and the lounge dining room was wedged open by a piece of metal. We were told this was so the member of staff preparing the meals could observe people in the lounge dining room and support them if they needed it. The use of this object meant this door would not be able to automatically close to ensure people were safe in the event of a fire in the kitchen or lounge dining room.

The manufacturer's instructions for the fire authority approved devices stated they must be 'checked weekly for operation as part of routine maintenance.' We looked in the fire log book but there was no record of weekly checks on the devices. We asked the manager for the maintenance schedule for the devices. They said they did not think there was one and they felt they were asked to maintain too many records. The manager had not identified in their audits that people may not be protected in the event of a fire.

The home's statement of purpose stated "All staff will be required to attend fire training on a regular basis and records kept of the dates of those training sessions." We asked staff about their fire safety training, so we could find out if they knew about risks in relation to holding fire doors open in an unsafe way. One member of staff reported they had not had fire safety training, two members of staff told us they could not remember when they last had fire safety training and another that they would like training. One member of staff did report they had received fire safety training during the past year.

We looked both at the home's training records and fire log book. There were no records to show staff had been trained in fire safety during the past year. As there were no systems to ensure all staff had been trained in fire safety and they were not aware of the risks of wedging fire doors open in an unsafe way, the safety of people and others in the event of a fire could not be ensured.

Other areas relating to avoidable harm had not been addressed to ensure the safety of people. A member of staff told us that due to people's needs, they used all the equipment provided "a lot" to support people in moving, including the hoist. As hoists are used to move people living with complex disability, manufacturer's instructions set out on the importance of their regular servicing to ensure the safety of people and staff. The manufacturer's instructions state their hoists need to be serviced by a person with sufficient training and experience, to ensure the safe operation of the hoist. There were no recent records to show the hoist had been serviced, as set out in manufacturer's instructions. We asked the manager about this. They said the home's maintenance worker checked and oiled the hoist. They were not able to confirm the maintenance worker had been appropriately trained in the ways advised by the manufacturers to ensure the safety of the hoist. There were no records to show the maintenance worker had performed the checks described by the manager.

Inadequate

Is the service safe?

People were not protected against risks of avoidable harm because risks relating to fire safety and the servicing of hoists to move people were not identified or managed effectively. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff what they would do if they were concerned about an adult at risk. They all said they would report the matter to the person in charge. We were informed by more than one individual of an incident which may have indicated a person might have been subject to abuse. We asked the manager about the incident. They told us they knew about the incident and had taken full action at the time to resolve the matter and that all parties were satisfied. We asked for records of what had occurred and the actions taken but the manager could only give us verbal information about the occurrence. They told us they had not made a record. They had not referred the matter to the local safeguarding team as they believed all parties had been satisfied with the actions they had taken. This is contrary to the home's own safeguarding policy which stated the manager will ensure that any allegation of abuse "is fully reported to the relevant adult protection officer of the local authority." It is also contrary to national guidance on safeguarding adults who may be at risk.

We were informed about one incident whereby a person sustained bruising following a fall out of bed. There were records relating to this incident. The manager told us of actions they had taken following the incident to ensure the person's safety. This also had not been referred to the local authority safeguarding team. We referred both matters to the local safeguarding authority after the inspection. They considered the information and reported they would not be taking the matters forward, but such incidents should always be reported to them for consideration. This was to ensure a review took place of the safety of people and any other individuals involved in the allegation.

Allegations of abuse had not been responded to appropriately. The manager had not followed the home's own policy or national guidelines on the alerting the local authority to possible abuse. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 6 August 2014, we identified that staffing levels were not appropriate. The provider sent us an action plan on 7 October 2014 in which they stated they were now compliant with staffing levels. At this inspection, we found there were enough staff on duty during the day but records indicated there were not sufficient staff on duty at night, to ensure people could have their needs met and safety ensured.

We asked people about staffing levels. One person said they felt there were more than the usual numbers of staff on duty that day, due to the inspection. However other people did not reflect this comment. One relative told us "There seems to be always staff around" and another relative told us, "There always seems enough staff, they are always in the lounge, or watching from the kitchen." A member of staff told us staffing "Had never been an issue" in the home. Another member of staff told us they had time to sit and talk with people. We observed response times when people used the call bell was prompt. There were enough staff at busy periods like meal times, to ensure people received support to eat and drink.

We asked to look at staff rosters to review overall staffing levels. The manager informed us they kept records of who was on duty in their diary. We asked if we could see the diary so we could verify staffing levels. They would not agree to us reviewing their diary. They said this was because it included other personal information and they also did not see the necessity for us to do so. The manager assured us there was always a registered nurse on duty throughout the 24 hour period and staffing levels were four in the morning, two in the afternoon and evening and one at night. The one member of staff on night duty was the registered nurse. The staff who lived in the building could also be available at night if necessary. Additionally she lived very close to the home and could be called in at any time. The manager reported the member of staff working on nights cleaned the kitchen, lounge dining room and laundry room. They did not feel the additional cleaning duties took the one member of staff working nights away from caring for people.

The manager had not assessed if one member of staff on night duty was sufficient to ensure people had their needs

Inadequate

Is the service safe?

met and were safe at night. One person remained in bed all of the time, three of the people were living with a disability and needed support from two members of staff to assist them to move. Other people were frail and would need to support to get out of the building in an emergency. Several of the people were also living with dementia and might not have been aware of risks relating to fire, so would need additional support from staff to ensure their safety during an emergency. The manager reported as some staff lived in the building, they would be available to support if necessary. However this was an informal arrangement, so the manager could not ensure staff would always be available in the building at night, as availability at night was not part of their expected duties. The home's fire risk assessment and fire evacuation plans did not take staffing levels into account to ensure the safety of people at night so people could be promptly supported when only one member of staff was on duty.

Staff told us there was one person who needed to have their position changed every two hours to prevent risk of pressure ulcers, including at night. We asked the manager how this person's position was changed safely by only one person. They said the person was not heavy and could be turned by one person. The manager reported they had not made a written assessment of this as they did not see the necessity of doing so. The home's moving and handling policy reflected the Health and Safety Executive guidelines (HSE) in stating that moving and handling assessments were needed, and these needed to be in writing. The policy had not been followed to assess if it was safe for the person to have their position moved by only one person.

Risks relating to the safety of people due to staffing levels at night had not been assessed. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 6 August 2014 we found recruitment procedures were not effective to ensure that only suitable persons were employed, and that required records were not kept on file. The manager sent us an action plan on 7 October 2014 in which they stated some areas relating to this Regulation had been met by that date and others would be met by January 2015. At this inspection we found nearly all the areas had been addressed. Some improvements were needed relating to certain areas in effective operation of recruitment systems.

We looked at the recruitment records for newly appointed staff. All included relevant checks on their background, including previous employment history and proof of identity. One member of staff had only one reference on file, not two. Therefore the manager could not fully show they had performed all the necessary required checks to ensure the person was suitable to work with people.

One person told us "New staff just seem to fit in." New members of staff had records to show disclosure and barring service (DBS) checks had been made. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people. However one new member of staff's DBS had been received eight weeks and another three weeks after they started working at the home. The manager said all new staff only worked under supervision and never worked alone until the DBS check was received. As noted above, we were not able to look at records relating to staff on duty to verify this statement. There was no written procedure about the issue. There was also no information on the individuals' files about this, such as a written induction programme or signed undertaking from the member of staff they would not work alone.

Administration of medicines was not always safe. Registered nurses used typed up medicines administration records (MAR) which documented what medicines were prescribed for each person, when they were to be administered, how often, and other relevant information. The administrator told us these MARs were held on the home's computer. The administrator told us each month the manager dictated any changes from the person's GP, they then ran off the following month's MAR. The manager confirmed this. The MARs were not signed and counter checked by a second person to ensure their accuracy against the GP's prescription. Nursing and Midwifery Council's (NMC) guidelines are that this is necessary to prevent errors in transcription. We saw such errors had occurred. This included a person who was prescribed a medicine which the MAR stated was to be given in milligrams but was prescribed for them in micrograms. If the MAR had been followed, the person could have been administered a significantly higher dose than they were

Inadequate

Is the service safe?

prescribed. Another person had an emergency medicine to be given by injection stored in the medicines fridge. The manager confirmed this medicine could be given in an emergency. The MAR did not include this among the current prescriptions for them. A person had a mood altering medicine documented on their MAR as prescribed to be given regularly, which the registered nurse stated they were given when required. The registered nurse reported this was a small home and all registered nurses knew about prescriptions. Guidelines such as those from the NMC have been developed because of a wide range of evidence relating to incorrect administration of medicines to people arising from incorrect transcription of medicines. The home was not following these guidelines.

When we looked in people's rooms we saw they used skin creams. Several people had skin creams with prescription labels on them which showed they had been prescribed for another person. Prescribed medicines are the property of the person they have been prescribed for and so may not be used for other people. One person had an anti-itching skin cream in their room. Where a person has itchy skin, this can be very irritating for them and may affect their daily life. The prescribed skin cream was not documented on their MAR or care plan. This was also observed for skin creams for other people. We asked staff about the use of skin creams. They gave us varied responses about systems used to ensure people had their prescribed skin creams applied regularly in accordance with their needs, and the prescriber's intentions.

A registered nurse supported a person in taking their medication. The person chewed their tablet into small pieces, swallowing the pieces gradually, being supported by the registered nurse in drinking to enable them to swallow the pieces. The registered nurse told us the person always took their medication this way. They did not know if the person's GP had been approached to ask them to prescribe liquid medication. There are a wide range of guidelines from the NMC and the National Institute for Health and Clinical Excellence (NICE) which state that altering a medicine from its current form can "compromise" its effect. There were no records to show the person's GP had been advised about this risk to the person or if the pharmacist had been contacted to check if the person's medication would continue to be effective if they chewed it up.

People were not protected against unsafe practice in the administration of medicines. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other assessments relating to risk to people were in place. A maintenance log had been set up since the last inspection. This showed when staff reported areas which needed attention and when they had been addressed. There were full records to show hot water temperatures were checked regularly to ensure they were within safe levels. The last checks on the fire extinguishers had been in January 2015. They had been undertaken by an external company. Records showed action had been taken to ensure they functioned as needed.

Inadequate

Is the service effective?

Our findings

People said they felt the home provided an effective service. One relative told us their loved one "could not have been in better hands." Another said "I cannot speak more highly of the care received." A member of staff told us staff did "such a good job looking after these people." However, we found Ashwood Nursing Home did not consistently provide care that was effective.

Certain areas of the service were not effective in ensuring good outcomes for people. For example staff supported two people who needed support to move from a chair to a wheelchair. They used an aid called a lifting belt to do this. They did not use the aid correctly, as they took some of the people's weight by lifting them under their shoulders. This has a potential to put both the people and members of staff at risk of injury. These ways of supporting the people took place in front of other staff but no one advised them about how to correctly use the equipment.

Several people were living with dementia. One of them repeatedly called out and also banged on the table in front of them. Other people were visibly distressed by the noise. Staff told us the person usually showed such behaviours and that other people could be affected by them. They were not aware of interventions they could use to support people who showed such behaviours such as using distraction or engaging with the person in something which interested them.

Staff we spoke with gave us varying replies about their training. Some staff reported they had been trained in supporting people who needed help to move, others did not. None of the staff we spoke with reported they had been trained in dementia care. One member of staff described the training they had received as "helpful" but did not expand to report on areas which they had learnt from training to support people living at Ashwood Nursing Home.

As we received varying replies from staff we looked at training records. These showed seven of the staff had been trained in how to safely support people with moving more than a year ago and three had no records of this type of training. None of the records showed staff had been trained in dementia care. We were unable to ascertain the proportion of total numbers of staff currently working in the home these represented as we could not review staff rosters, and the home did not have a central way of recording or planning training.

Systems for staff training and supervision had not ensured staff had the knowledge and skills to enable them to provide care effectively, this included supporting people in moving safely and care for people who were living with dementia.

Staff had not been supported in other ways to ensure they could provide effective care to people. A person's relative told us they found some staff lacked English, or had really strong accents. They reported this could be a problem when such staff were communicating with people or between themselves. When we requested to interview a member of staff, the manager insisted on staying with us because they said the member of staff's English was not good enough and they may need support from them. When we spoke with the member of staff they could not understand commonly used English words including "upstairs." When we asked them what they would do if they observed a person had sustained a bruise, the manager prompted them and told us what actions the member of staff would take. The member of staff's English was not good enough for them to explain to us how they supported a person who was living with dementia.

We looked at supervision records for two new members of staff. One noted the member of staff's language difficulties and the need for them to ensure they were asking for clear instructions. The other new member of staff's record stated the person needed to ensure people had understood them because English was not their first language. Neither record identified training needs or available support for development of their English language, to ensure these staff had the language skills they needed to meet people's needs.

Staff did not have the knowledge and skills to ensure they could deliver care people needed safely and to an appropriate standard. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No one was subject to a Deprivation of Liberty Safeguard (DoLS) when we inspected. Some people were living with

Is the service effective?

dementia. No one had an assessment of their capacity completed in accordance with the Mental Capacity Act 2005 (MCA). One of the people sat in a chair which they could not get out of independently. Staff reported this was for their comfort. There had been no consideration whether this could have been a restriction of their liberties. Where decisions were made about people's best interests, these were not documented to enable review. One person's relative told us they had been involved in a decision to put bed rails in a raised position on their loved one's bed, after they had rolled out. The consent form for this had not been signed or dated and there were no records of when this decision had taken place. Therefore systems were not in place to ensure regular review of the decision or if it should be considered a deprivation of their liberties.

None of the staff said they had received training in the Mental Capacity Act or Deprivation of Liberties Safeguards (DoLS). The manager told us they had received training in these areas but said it had not been recently. As staff had not been trained in such areas they could not tell us and were not aware of their responsibilities under the Act and safeguards to ensure they act in a person's best interests.

There were not suitable arrangements to obtain and act in accordance with the consent of people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns Ashwood Nursing Home was effective in other areas. Staff sought people's verbal consent whenever they were giving them care. This included asking people if they wanted to go to the toilet, if they could support them with eating and drinking and if they could support them with moving.

People said the food was good. One relative told us their loved one "Enjoys the meals, they're always good". Another relative told us "In fact food is always excellent." A person enthusiastically described the soup as "good" to us at lunchtime. A member of staff supported a person in having a drink of orange, they smiled at the member of staff and said "That's nice" in an appreciative manner.

The lunchtime meal smelt good. People were clearly enjoying eating their meals. The cook ensured each meal was nicely presented. The home used a cloth table cloth on the dining table, metal cutlery and glasses. When people requested second helpings, these were given to them. Staff sat with people who needed support helping them to eat in a kindly way. We observed a member of staff assisting a person to eat who remained in bed all the time. They sat with the person, carefully supporting them in eating at their own pace. They checked with the person if they were ready to eat the next mouthful, listening for their response.

People told us they were impressed by the way the home called in people's GPs when needed. One person's relative told us they were pleased the home had organised regular chiropody for their loved one. The manager informed us about the ongoing work they were undertaking to access community dental support for people who needed it.

A person's relative told us the staff had been quick to notice changes in their loved one and promptly call in their GP when they became acutely unwell during a bank holiday. The home manager said they had been called in by staff, when they were off duty to support the person during this period. The registered nurse told us about the on-going support and observations of this person following their acute episode. One person told us their relative was very susceptible to infections and the home called their GP in very promptly when they showed signs of infection.

Inadequate

Is the service caring?

Our findings

People gave us mixed comments about the caring approach of the home. One person told us they did not feel all staff understood how they felt. This was not echoed by other people. One person reported "Now I am here it suits me very well. I'm very well looked after." A relative told us their loved one "Is extremely happy and settled at Ashwood House." Another relative told us their loved one was treated with "courtesy, kindness and respect." Although people spoke positively of the care they received, we observed care practice which was not caring.

Staff did not always show people compassion and respect, this included people living with dementia. One person in the lounge dining room asked "Is it nearly bed time?" during the morning, more than once. Staff did not respond to these questions from the person to orientate them to what the time was and reassure them.

Staff did not involve people with decisions about meal options and support them in making choices. For example, a person asked a member of staff for a salad just before lunch. The member of staff told them they would be given the salad. The person was given the same meal as everyone else. We asked the cook about this. They said the person's relative regularly brought them in salads to eat, which they liked. The person was given these salads at supper-time. This information was not documented in the person's care plan. The member of staff the person had asked about the salad had not involved them in making this decision about when they would prefer to have their salad. At lunchtime people were not informed by staff of what the different courses were. We asked one person about their soup. They said they had liked it but they did not know what they had been eating.

People who were living with a disability did not receive the support they needed to eat their meals independently. One person remained sitting in their chair with a table in front of them. Staff did not place their table closer to them for the meal. The person was also only able to use one hand to eat. They had difficulty in placing their food on their cutlery due to this. These two factors meant they dropped some of their food down their clothes throughout the meal. Staff reported this was how the person usually ate. There was no information in the person's care plan about how they were to be supported to eat, apart from a statement that on some days they needed to be given assistance with their meal. There was no assessment of aids which could support them in continuing to eat their meals independently and with dignity.

People all had detailed information in their care plans about their past lives, interests and experience. This information was not used by staff when giving people day to day support and care, including supporting them in reminiscence. For example, from a person's accent it was clear they came from one particular part of the United Kingdom. When we asked about the person's accent, the member of staff supporting them told us they did not know the area the person came from. The information about this person's past life was also not used by staff as means of opening discussions or diverting the person when they showed signs of confusion and distress.

Staff did not respect people's privacy and dignity by following their own statement of purpose or guidelines on privacy and dignity from the Social Care Institute for Excellence. For example, a range of staff walked into people's bedrooms without knocking or gaining consent. This also included the registered manager. Documentation confirmed staff had not received any training on the principles of privacy and dignity.

People could not always go to bed when they wished. People who required support of two staff members to go to bed had to go to bed before 9.00pm. This was because there was only one member of night staff on duty. This did not empower or enable people to live automous or independent lives.

A dementia friendly environment can help people be as independent as possible for as long as possible. It can also help to make up for impaired memory, learning and reasoning skills. The provider had not created an environment which promoted the well-being of people living with dementia. Some doors across the home looked identical and some did not have the room number on it. One room had the wrong name displayed outside. The person who lived in that room did not know why there was the name of a person with the opposite gender outside their room.

The home was not consistently ensuring people were involved in making choices, their privacy upheld and they were treated with respect. This is a breach of Regulation 17

Inadequate

Is the service caring?

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we observed some practice which did empower people to make their own choices and saw staff were caring towards people. A person told us "Nobody bothers me, I get up early or late as I choose." A member of staff asked a person if they wanted a drink. They gave them a range of choice of different hot and cold drinks and checked back with the person they had made the choice they wanted. Staff always asked people if they wanted to go to the toilet and asked their permission to support them. Where the person needed their feet putting on or taking off the foot-pedals of their wheel-chair, staff always asked permission to do so. A member of staff asked a person if they would like to go out into the garden as it was a nice day. They respected the person's decision that they did not want to at that time.

Staff knew about some of what was important to people in their daily lives. A person said they were concerned about their cat. At a busy time, a member of staff went to look for the cat and brought it to them. The member of staff told us the person's cat was very important to the person and had been admitted with them to the home. The cat looked very well cared for.

People's rooms were very personal, reflecting their likes and previous interests. A person's relative told us their loved one liked "rummaging" in their drawers at night. They appreciated the way their loved one was able to do so and such activities at night were not seen as a problem.

Throughout the inspection, we observed elements of practice which upheld people's privacy and dignity. Staff always addressed people by their preferred name. A person went to use the toilet independently. They left the toilet door open. A member of staff noticed this very promptly and asked the person's permission to close the door, explaining why they needed to do this to ensure the person was private. A person's relative told us the staff responded efficiently to their loved one's requests to go to the toilet and respected their dignity at such times.

Inadequate

Is the service responsive?

Our findings

People were positive about the responsiveness of the home. One person said that their relative was "extremely happy and settled at the home." A person reported the home was responsive, providing "a good routine" for their loved one. People had different views about their involvement in care planning. One person's relative felt they had not been involved in supporting their very frail loved one in developing their care plan. This was not echoed by other people. Another person's relative reported they were involved in their loved one's initial assessment and "About once a year" had been invited to read and sign the care plan reviews. They said they could "Have a say, everything is transparent." Another person's relative also reported they had been involved in care planning and were invited to comment and had signed care plan reviews.

People's needs were not consistently responded to in the way they needed. Several people had been assessed as being at high risk of developing pressure ulcers. Two of these people spent most of their days sitting in the lounge. Staff told us neither person was able to get out of a chair without assistance from them. Risk of pressure ulceration does not reduce when a person is sitting out of bed. We asked staff how they reduced people's risk when sitting in the lounge. Staff could not tell us on actions they took to reduce people's risk, such as the use of pressure relieving aids and ensuring the people were regularly supported in moving their position, to relieve pressure. Neither person's care plan had information on how their risk of pressure ulceration was to be reduced. Staff we spoke with confirmed they had not received training on the prevention of pressure ulceration. Therefore people's needs were not being responded to, to reduce their risk of developing pressure ulcers.

One person was living with diabetes. The manager had a good level of understanding about management of diabetes and reported they were always happy to attend the home if the person needed management of their condition when they were off duty. They told us the person could "suddenly loose blood sugar levels and just drop so we have to be very careful." The person's care plan stated when the person's blood sugar levels were low, staff were to administer a specific medicine used for low blood sugar levels. The person's medicines administration record showed this was not currently prescribed for the person.

The care plan did not have instructions on what other actions staff were to take at such times, including when their blood sugar levels should be re-checked or how long a member of staff should stay with them during and after an episode. Staff, including the registered nurse were clear on actions they should take if the person was experiencing low or high blood sugar levels. They also reported they had not received training in the area.

The planning and delivery of people's care did not meet their individual needs and ensure their welfare. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us about the lack of activities. One person reported they felt their loved one was "Lonely a lot of time." Another person reported "They have music in from outside every few months, the last was Christmas I think." A member of staff told us people did not do much and they would value dementia training. They mentioned the Christmas entertainment as something that had achieved a positive response.

People who sat in the main lounge dining room were mainly either asleep or sat with their eyes open, but not engaged with their environment. They were not supported in engaging with either group or individual activities. The television was on. Staff did not check with the people if they wanted it on, if they liked the programme or could see it from where they were sitting. They did not use what was happening on the television as a topic for conversation with people.

Staff did not provide people with any activities suitable for people living with dementia. We saw some people were holding conversations with people whom they could see but were only visible to them. Staff told us this was normal behaviour for these people. Staff did not intervene to support them and orientate them to where they were or who was with them. One person said "What do I do now?" on more than one occasion. Staff did not discuss with the person what they would like to do, apart from offering them a drink.

This lack of support to people with activities shows the home was not following their own statement of purpose which stated they "continually offer a wide range of appropriate social and leisure activities." It also stated they

Is the service responsive?

promoted "both group and individual activities that encourages service users to express themselves as individuals. Helping service users to overcome any shortcomings that they may experience."

People's care plans were not being followed by staff and they did not describe how staff were to support people living with dementia with engagement. One person's care plan stated staff were to encourage them to come to the lounge and interact with other people. It then stated staff were to support them with interaction if they needed help. Their care plan did not outline how to support the person, what activities were important to them or what meaningful activities may promote their well-being. Staff did not encourage the person to interact with other people during the inspection. Another person's care plan stated staff were to keep the person "occupied and motivated, support choices, give reassurance." There was no guidance how staff were to do this. The care plan did not document the person's repetitive behaviours or how staff were to support the person when they showed such behaviours.

The people's care and treatment was not appropriate for their individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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People gave us varying comments about what they did if they had concerns or complaints about the service. One person told us they did not raise matters they were concerned about because "It makes such a stink it's not worth it." This was not echoed by other people. One person told us "I don't think I've complained about anything, just lucky to be here." A person's relative told us "Everything you come up with they deal with and sort."

The complaints procedure was displayed in the front entrance hall. We asked to look at the complaints book. The manager told us "I have a complaints book but I don't write anything down." This was because all issues were "dealt with immediately."

We were informed about a range of different matters which people said they had concerns about. For example, a relative told us they had raised the issue of their loved one having a bruise on part of their face. They said staff had identified the bruising as having related to part of their bedroom furniture and had moved it. We looked for a record relating to this issue but none had been made. A relative told us they had raised concerns about the length of time it had taken to mend a faulty toilet. There were no records relating to this. A relative told us they had informed the manager of a problem with the curtains in their loved one's room and of the actions they had taken to rectify the matter. No record had been made of this. We noted a record in a daily report that a person's relative had made a complaint. We asked the manager about this. They said they had not documented the complaint as it had been resolved at the time.

As such matters were not documented, the manager could not be assured they had followed their complaints procedure and all parties had been satisfied with the response. They were also not able to review complaints to ensure they continued to be responsive to people's concerns. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some examples of responsive and personalised care. Two people were supported in going out of the home by members of staff when they wanted to. A person told us they went out to the local church every week. A person who remained in bed all the time had their bed positioned so they could look out over the home's garden. Relatives reported they were supported by the staff in visiting as often as they wanted to. One relative reported staff were "so supportive of us all." Another one "I always feel very welcome, it's very homely."

Inadequate

Is the service well-led?

Our findings

People said they thought the home was well-led. One person's relative told us "I have confidence in these people." Another person's relative described the home as "not institutional, feels family oriented, not impersonal." We found Ashwood Nursing Home was not consistently well-led.

The home had a registered manager in post. The manager was also the home owner. The manager had experience of managing the home for many years. We asked people about the manager. We received mixed comments. One person told us "There isn't a manager." One person's relative felt the manager was often not in the home. This was not echoed by another person's relative who reported the manager was "permanently available and interested." Another person's relative described the manager as an "extremely competent leader."

The manager reported they did not use formal audit systems to review the quality of service provided to people. Audit systems ensure issues relating to quality of care are identified and action taken to address them. The manager told us quality audits "Would involve more paperwork, and you can see I don't do paperwork". They said because they were frequently in the home and worked alongside staff, they were in a position to monitor the quality of the service all of the time, and make necessary improvements.

The manager told us as well as being regularly available to audit the quality of the cleaning she were also happy to do any cleaning which needed doing. Some areas had not been identified by the manager's systems. This included the back and undersides of the bath hoist, which showed yellow staining, and a raised toilet seat which showed debris stuck on its under surface on both days of our inspection. Other areas which had not been identified were commode chairs which showed dust and debris on their lower chassis and wheels. The plastic covers to commode chairs were deteriorating, so were no longer intact and therefore could not be wiped down to ensure cleanliness. The manager's systems for audit had not identified these matters, therefore action could not be taken to ensure cleanliness and reduce risk of cross infection.

The manager's audit systems had also not identified they were not following their own medicines policy. This stated that 'The identification of waste medicines will form part of the day to day management and review of medicines'. We saw two medicines which were to be given by injection, stored in the medicines fridge, which were out of date. We also saw an opened skin cream in a person's room which was dated as expiring in September 2014. The manager's systems for audit had not identified these matters.

The manager's auditing systems had also not identified they were not following their own policies in relation to supporting people to move. This policy stated risk assessments relating to moving people "will be reviewed on a monthly basis or more frequently if circumstances change." We looked at a person's care plan which stated they were unable to weight-bear and a hoist was always to be used. This was dated 20 May 2013 and had been evaluated every month, most recently on 2 December 2014 where it stated "no changes." We saw this person being supported to move by staff using a lifting belt and holding them up under their arms. A different person had a care plan dated 6 February 2015 which also stated they were to be moved using a hoist and sling. This person was also moved using a lifting belt and by holding them up under their arms. A member of staff confirmed that staff used a belt, not a hoist to move the people. The manager told us they regularly worked as a member of staff in the home. Despite this they had not identified staff were not following the care plans and they had not re-assessed the people to ensure they were being moved in a safe way.

People were not protected against risk because there were not effective systems to assess and monitor the quality of the service. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection on 6 August 2014 we found people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. The provider sent us an action plan on 7 October 2014 in which they reported that most areas had been addressed, other areas would be completed by January 2015, apart from quality assurance records which would be 'ongoing.' Despite this action plan, we found at this inspection that there continued to be among other areas, no documented quality assurance documents and no written staff roster.

Inadequate

Is the service well-led?

The manager had not ensured a range of other records were in place and were accurate. We asked the manager about this. They said "You can't keep making records when you're trying to look after people, records are secondary." The records of an accident to a person showed different information on the record to what was documented on their body map. We were told the person had shown bruising to their face and body following the injury. There were no records of the bruising or its progress resultant from the injury. Therefore the effect of the injury on the person could not be fully assessed.

A person had a medicines administration record which stated their pulse was to be taken every day and it if was over a certain level, they were to be given a specific medicine which slowed and strengthened their heart-beat. Their record showed a gap of four days when their pulse had not been taken. As it had not been documented for these four days, the manager could not be assured during this period that the person's condition had remained stable and they did not need the medicine.

One person's records documented they could show certain behaviours. Staff told us about these behaviours but said they did not write them down when they happened. We asked the manager about the behaviours. They told us the person showed these behaviours in "bouts." As these behaviours had not been documented, there was no information on the frequency of them or any triggers so their care plan could be further developed to support the person. It also meant relevant external health care professionals could not be accurately advised of the type and extent of these behaviours to ensure they were managed in a way to support the person.

The Nursing and Midwifery Council (NMC) in its Code of Professional Standards of Practice and Behaviour for Nurses sets out clear guidelines on the registered nurses responsibilities for the maintenance of accurate records. The manager was not ensuring these guidelines were followed. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's web site stated their philosophy was to "Endeavour to build a relationship with the whole family. There is a lot we can all do to make life at Ashwood comfortable and enjoyable simply by talking." It also stated because of the manager's "Day to day involvement, you can be sure that what she tells you is first hand and accurate." The manager told us because they were frequently in the home they received comments directly from people about their views of the service.

There were varied responses when we asked people about how they fed back to the manager on the quality of the service. The home did not hold residents and relative meetings or other systems of receiving regular feedback. One person told us they had never received a survey so they could give formal feedback. However another person told us they had a feedback survey a "few months ago." They had not been made aware of any issues or responses arising from it. The person told us they were concerned because the home could sometimes be "chilly". They told us the re-decoration programme had made a big difference, as the home was "tatty" before it took place. Another person also commented positively on the effect of the redecoration of the home, saying it gave it a fresh appearance. A relative commented positively on the plentiful contact from the manager, who was permanently available and interested. However, there was lack of consistency in receiving feedback from people and therefore the manager could not be assured that everyone received the service they wanted or expected.

We asked people and staff about the philosophy and culture of the home. Some people told us the manager was not always available and when they were, was not prepared to hear what they wished to report. One person reported they avoided contact with the manager due to this. Another person told us about the visiting patters they used for their loved one, due to what they felt about the culture of the service. A member of staff reported there had been had one staff meeting only, which was "To get to know the team", but many staff had not come. The manager gave us minutes of a staff meeting dated 12 December 2014, which was attended by seven staff plus the manager. These showed discussions took place about laundry and cleaning duties. The minutes did not show issues relating to the service's philosophy in supporting people and their families or the quality of the service were discussed.

However these responses were not echoed by all people and staff. One person told us they liked the culture of the home because "it's a friendly place." One member of staff reported they felt the manager listened when they raised

Inadequate

Is the service well-led?

issues. They had gone to the manager with a problem because of the organisation of one particular area, and it was sorted out. A member of staff described the manager as "so caring." Another member of staff told us about the good team work, saying "It is good always trying to share problems together."