Surrey and Borders Partnership NHS Foundation Trust

Ashmount

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Ashmount is a service for up to seven people who have a learning disability or are on the autistic spectrum.

The main inspection took place on two days. The 20 May and 4 August 2015 and was unannounced. We returned to the home on 7 August 2015 as the provider had been able to find some information that was missing on 4 August 2015.

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 and associated Regulations about how the service is run. The registered manager was not present during our inspection. There was a new deputy manager to the home who was present on the second day of our inspection. The acting manager was present on the third day.

Summary of findings

The provider did not deploy staff appropriately. We found staff sitting around chatting to each other whilst people were wandering outside in the garden unsupported. We witnessed other situations were people may be put at risk because of staff not being available.

Staff did not always understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Some best interest decisions were made in line with legislation. We found though that people had not had mental capacity assessments with regard to the locked gate and some restrictions were in place but not authorised. We found in some instances staff had not considered the least restrictive option for everyone living at Ashmount.

People were not involved in making choices about the menu and the meals were not always the most healthy. Staff supported people to access health care professionals, such as the GP or speech and language therapy team.

Although we observed some good examples of kind care from staff, we found people's dignity was not upheld by staff. People were not made to feel they mattered or shown respect by staff. People were living in an institutionalised way.

The premises were unsuitable as they were dirty and not homely. People's rooms were sparse and some had no curtains or blinds.Toilets had no running water or hand drying facilities available to people all the time.

Activities were not individualised or meaningful to people and did not occur regularly enough. People were not supported to access the community as much as they could. There was no structure to people's day.

Risks for people around their medical conditions and their health needs were not always being monitored appropriately by staff. It was difficult to identify if people received care responsive to their needs. People were not involved in developing their care plan.

Staff knew the procedures to follow should they have any concerns about abuse taking place in the home. Risk assessments were carried out for people to maintain their individual safety, however we found some of those were not complete meaning people could be at risk of harm.

Staff did not always know how to support people when visitors came to the home. There was inconsistent practice from staff meaning people were not supported in a cohesive way.

Quality assurance checks were carried out but actions arising from these weren't always addressed.

Staff did not always have access to people's care plans or have the support from senior management.

Staff followed correct and appropriate procedures in relation to medicines to ensure people received their medicines safely.

Care was provided to people by staff who had access to relevant training. Staff were given the opportunity to meet with their line manager on a one to one basis and their competencies were checked by management.

Complaint procedures were available to people. Relatives knew how to make a complaint.

The provider had ensured safe recruitment practices to help them employ staff who were suitable to work in the home.

People's care and support would be uninterrupted in the event of an emergency.

During the inspection we found some breaches of 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 the report.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the

Summary of findings

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

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

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?

Inadequate 

The service was not safe.

Staff were not deployed appropriately in the home to keep people safe.

Risks plans were in place, but guidance to staff on how to mitigate the risks was not always available.

The provider carried out appropriate recruitment checks.

Staff were trained in safeguarding adults and knew how to report any concerns.

Staff followed safe medicines management procedures.

Staff had information on what to do in the event of an emergency.

Is the service effective?

Requires improvement 

The service was not effective.

Staff had an understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act but did not always follow the legal requirements in relation to these.

People were not enabled to participate in developing the menus or always provided with healthy food.

Staff had access to relevant training and had the opportunity to meet with the line manager on a one to one basis.

People had access to external healthcare professionals.

Is the service caring?

Inadequate 

The service was not caring.

People were not provided with an environment that upheld their dignity or respected them as individuals. People were living in an institutionalised way.

We saw some good examples of care from staff, but staff did not always ensure people were made to feel they mattered.

Staff did not show people always compassion.

Is the service responsive?

Requires improvement 

The service was not responsive.

People were not enabled to participate in meaningful, individualised activities or encouraged to be involved in choices and decisions around their care.

It was difficult to identify if people were provided with care responsive to their needs as not everyone had a positive or proactive support plan.

Summary of findings

People were given information how to raise their concerns or make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

Staff were unsupported by senior management and their was no management oversight during our first visit in August.

Quality assurance audits were carried out to monitor the quality of the service but actions identified had not always been completed.

People and relatives did not have the opportunity to participate in the running of the home.

Ashmount

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 checked 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 reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were carrying out this inspection in relation to some concerns we had received about the home.

This inspection took place on 20 May 2015 and 4 and 7 August 2015 and was unannounced. The inspection team consisted of four inspectors and an expert in experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

We were unable to speak with people as part of our inspection, instead we observed care and interaction between staff and people. We observed staff carrying out their duties, such as assisting people and helping people with food and drink. During the inspection we spoke with the registered manager, acting manager, deputy manager, a Trust service manager and four staff. Following our inspection we spoke with two relatives and one healthcare professional.

We reviewed a variety of documents which included two people's care plans, medicines records and policies and procedures in relation to the running of the home.

The home was last inspected on 10 July 2014 when we identified there was 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.

Inadequate

Is the service safe?

Our findings

Relatives told us they believed their family members were safe. One relative told us their son was happier than he had ever been however we found that people were not always protected from the risk of harm.

People were cared for by staff who were not deployed effectively. Although there were a sufficient number of staff during our August inspection, we saw housekeeping staff acting as care staff during the day and care staff not supporting people when they needed it. We saw the domestic staff spent much of their time in the dining room at lunchtime and sat or stood in the dining room most of the afternoon. One staff member told us they often did that and had, "A good rapport with people." The deputy manager told us that no one required one to one care, however we saw a member of staff sit with one person for most of the day. It was not evident why this was as most of the time the person they were sitting with was asleep.

We were told four staff would be on duty in the morning, four in the afternoon and one covering both shifts which included a nurse. At night people were supported by two waking staff. There was one domestic staff and care staff undertook the cooking all week and the laundry and the cleaning at weekends. The deputy manager told us there were times they, "Fall under the staffing levels. Sometimes at night." Staff said there were enough of them during the day, but things were a struggle at night at times. One person did not sleep well and often required two staff to support them, when this happened other people were left unsupported. Staff told us when staffing levels were short during the day people became anxious as they were unable to go out. They told us there should always be a nurse on duty each day however, there were times this was not the case. On those occasions staff had to ask nurses from other locations for help and support. Following the inspection the trust clarified with us that a registered nurse should be on site at Ashmount during each shift.

During the day people were at times left unsupported or unsupervised by staff. On the first day we saw staff were clearing lunch away. One person who was not allowed to have too much to drink due to a medical condition took a jug of juice and drank from it before staff appeared back in the dining room. On another occasion we saw one staff member in the dining area trying to manage three people who were attempting to grab hold of cups and coffee from a tray they were carrying. On the second day we saw three people in the garden were left unsupported for a long period of time as staff were either indoors chatting to each other or in the kitchen. We saw four people going out in the bus in the morning with two members of staff. We were told by the deputy manager they were going, "Personal toiletry shopping." However, we heard from staff that because of people's behaviours they were unable to let people off the bus because they needed one to one support when they were out in the community.

On the first day a member of staff told us there were often agency staff working at the home which mean people became anxious as they were not familiar with them and at times there was only one permanent member of staff on duty. However, staff did say that things were improving and less agency staff were being used wherever possible. The deputy manager confirmed this saying they tried not to use agency staff, but staff told us, "It's hard to recruit on the pay levels."

People may be at risk by being unaccompanied when outside. We were told staff were allocated duties and would know what they were doing. It was clear from our observations that staff did not know who they were supporting. On two occasions there were three people in the garden on their own and two staff members sitting in the lounge on their own. Throughout our visit on the second day, people spent a lot of time walking around the building and garden. Staff were seen to be stood in the lounge, walking around the building or sat down. This gave the feel of the home being 'patrolled' by staff.

The lack of appropriately deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out safe recruitment practices. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw evidence of information being obtained, such as references, health declarations, full employment history's and Disclosure and Barring (DBS) checks. DBS checks identify if prospective staff have a criminal record.

Accidents and incidents were recorded formally on the Trust electronic system (Datix) and included details of the accident. However possible causes and ways to prevent

Is the service safe?

further reoccurrence were not always included. One person displayed particular behaviours, but there was no information as to what action had been taken or what could be done to help prevent reoccurance.

Staff did not always follow instructions to keep people safe. One person had a customised harness for travelling in the bus. This had been broken for a couple of weeks so it was unsafe for them to go out. Two staff members told us they had borrowed a bus from another service and had taken them out as they knew they liked going out despite the fact this bus did not have an appropriate harness. The daily activity recording showed the person had been out four times.

Staff did not take action to keep people safe from harm. Staff did not ask us to sign in on either of our visits in August. We read from one 'board walk' visit by senior management they had to remind staff to ask them to sign in. Staff did however have an understanding of the different types of abuse and described the action they would take if they suspected abuse was taking place. They were able to tell us where to find the policy which would give them guidance on what to do and one member of staff told us how they had previously reported an incident. Staff were able to tell us of the role of the local authority in relation to safeguarding but there was information available to people on the noticeboard in the main entrance. Staff told us the Trust had a whistleblowing helpline they could use if they had any concerns.

Staff did not always know the medical conditions of people. One member of staff told us about a particular health problem relating to one person, but was unable to describe what intervention, treatments or action was required to keep this person safe. They said only the named nurse would have that information, despite the member of care staff being the keyworker for this person.

One person had PICA (an eating disorder) and although there was information about the risks to them, there was little guidance to staff on how to support them. This same person required their blood pressure and weight monitored regularly. We saw their weight was checked weekly but their blood pressure was last taken in April 2015. There was no trigger to staff to indicate how long they should wait before they sought medical intervention.

Another person was at risk of choking and although there was clear guidance from SALT. This person required regular blood tests, but there was no information to show how often 'regular' was.

The lack of safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were unclean and not fit for purpose. In the laundry room we found the washing machine powder dispenser dirty and broken. The tumble dryer was stained and the yellow waste bin was rusty and the foot pedal didn't work. The bathrooms and toilets had stained toilet bowls and stains around the toilet basin and on the floor. There was mildew on the ceiling of the bathrooms. Windowsills in bathrooms were cluttered and we saw a plastic jug in one bathroom which was dirty. The extractor fans were clogged with dirt. Two brushes which were used to sweep shower water away had broken handles leaving exposed rusty metal. The plug for one bath was black with mildew and there was a wooden chair that water had seeped into the bottom of the chair legs leaving an unpleasant smell. One bathroom had a small cupboard with the door hanging off leaving exposed pipework and the bath tap tops were missing. The bath was rusty in places and had dirty grouting around it. The mirror was dirty and there was stagnant water in the shower drain.

In one of the lounges a television aerial was hanging down behind the television which was accessible to people. The conservatory was dirty with cobwebs on the glass roof and thick dust around the base. We noted the dining tables had thick dirt around the base of the legs. Another smaller lounge had stains running down the walls. The provider has since told us they have arranged for the home to have a deep clean on 11 August 2015. They confirmed the cleaning schedule has been reinstated for the housekeeper and an additional cleaning service has been commissioned for the home.

People's bedrooms were sparse, un-personalised and bedding was not always appropriate for them. There were blinds at one person's windows which were covered in thick dust whilst another room had a strong smell coming from it.

The lack of appropriate premises was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Staff followed correct medicines procedures and medicines were stored appropriately. Staff recorded the room temperature on a daily basis to ensure medicines were stored correctly. Each person had a medicines administration record (MAR) chart which stated what medicines they had been prescribed, what they were for and when they should be taken. MAR charts included people's photographs and there was a signature list to show which staff were trained to give medicines. We saw staff give medicines to people and sign the MAR chart afterwards once they were satisfied they had taken all of their medicines.

People who required PRN ('as required') medicines had guidelines in place. This gave information to staff why they may need the PRN and what behaviours they might display to show they were in pain.

In the event of an emergency people would be evacuated from the building in a safe way. We read people had individual personal evacuation plan (PEEPs) in their care plans. This gave information to staff on what this person should need in the event of a fire or emergency. People would be evacuated to other locations within the same site as a place of safety.

Requires improvement

Is the service effective?

Our findings

People's rights were not always protected because staff did not ensure they followed the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm.

Although staff had an understanding of the MCA and DoLS, staff had not carried out mental capacity assessments on people in relation to decisions to ensure they were following the correct legal procedures. Staff told us that MCA and DoLS were, "Able to empower people who may or may not have choices." Staff had some understanding of best interest decisions. One member of staff told us (in relation to a person still in their dressing gown mid-afternoon), "Well it's his choice, MCA and all that, he can choose." On the second day we were told by staff they believed no DoLS or MCA assessments were in place and they could not find any information on the care planning system (RIO). However when we returned on 7 August 2015 we saw that DoLS had been authorised for people and renewal applications had been submitted. These were in relation to different restrictions such as the locked front gate, access to the kitchen and some rooms such as the laundry room and bathrooms.

People had restricted access to certain parts of the home. Some doors locked automatically when they closed and were operated with a magnetic fob. Staff had not considered a best interest decision to consider if people had capacity to have their own fob for their room. Staff had not contemplated less restrictive options in relation to the locked kitchen door as this meant a restriction for everyone, rather than just for the people it affected. For example, by moving items or food or ensuring staff accompanied people at all times in the kitchen. One relative told us their family member who could make tea now couldn't because the kitchen was locked for other people's needs.

The lack of following legal requirements in relation consent to care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had access to regular and appropriate training. We asked staff if they had received training specific to the needs of the people living in the home. Some staff told us they had received MAYBO (conflict management) training. They told us they were told about strategies/warning behaviours that people may display although this was not accessed through any formal training. One member of staff told us they had not received any training on de-escalation techniques and another said they were behind on some of their training. Other staff told us they felt they had sufficient training and believed the training within the Trust was good. Following the inspection we received information from the Trust confirming 11 staff had received MAYBO training and six staff were due to take refresher training.

Staff did not always receive regular staff supervision to ensure they were putting any training into best practice. Staff told us supervisions should take place every six months, and said they could request additional supervisions, however we found four out of 10 staff had not received this. The deputy manager told us they had not had any formal supervision with the acting manager. They said they felt supported by the acting manager as well as senior management and there was always an on-call manager available. Staff told us their appraisals were not up to date which meant staff did not have the opportunity to meet with their line manager on a one to one basis to discuss their development. Following the inspections we were told by the trust that approximately 90% of staff had received appraisals and supervisions.

We recommend the provider ensure staff supervisions and appraisals are carried out consistently in line with the Trust policy.

People were not involved in developing the menu. Staff told us they developed a four-week rolling menu based on what they saw people eat. They said the menu went back, "For years, although it has been tweaked at times when people appear to show a dislike to the food." We were told that people were unable to use pictures to make food choices but we saw some people had these in their bedrooms. It was recorded in one person's care plan, 'food – pictures can be used'. We saw people had a choice of sandwiches, crisps, yoghurt and fruit for lunch. The range of meals did not always appear to be healthy or nutritious. We saw on our earlier inspection that people had potato wedges, fried chicken and coleslaw one day and another,

Requires improvement

Is the service effective?

chips, eggs and beans. Staff said they were trying to introduce more fresh fruit to people. Drinks were provided, although it was not clear if people were given a choice of drink.

One relative told us that prior to living at Ashmount their family member had regularly refused to eat and had thrown away their food. They said what they particularly liked now was having a takeaway on a Friday night and a cooked breakfast at the weekend. Another relative told us the lunches, "Look quite nice" when they visited.

People who had specific dietary needs were provided with appropriate food. One person required their food to be of a soft consistency and we saw staff correctly prepare this for him on a lipped (non-spill) plate.

We recommend the provider consider ways to involve everyone in choosing which foods they would like to eat.

Staff did not always know how to provide effective care. The deputy manager said that new staff or visitors could cause a disruption for people and trigger different behaviours. They tried to encourage relatives to telephone first to minimise this. On the second day staff were only able to find two care plans and could not access RIO. The care plans they gave us held little guidance for staff on how to defuse situations or what distractions they could use to help ensure visitors had as little an impact as possible for people. Throughout the day staff did not provide people with appropriate support when they were anxious. This resulted in inspectors being pulled around the building by people who wanted to communicate their wishes, access their rooms or leave the building. One member of staff appeared scared when two people displayed demanding behaviour. Despite staff telling us people were reviewed by the behavioural support team as care plans could not be found, staff were unable to assure us appropriate guidance for staff was recorded or followed. On the third day of the inspection, staff were able to show us care records for each person living in the home.

Staff understood people's individual ways of communicating. For example, some people would 'lead' staff to what they wanted, others used simple words or sounds. However, staff had not considered other ways to encourage communication or to signpost people. One member of staff said no one used any communication systems and would generally show staff what they wanted by taking them to things. However, we found some people spoke when they had something that motivated them for example, when one person wanted to clean their teeth. This showed they had capacity to add to their speech. We asked about the use of photographs or pictures but were told one person had an eating disorder which meant they would try to eat paper, so they could not use these. However we saw some rooms had pictures on the doors which contradicted what we had been told. Staff were unable to explain why there was not consistency in relation to pictures in the home.

Staff involved healthcare professionals when appropriate. We heard that one person had a physiotherapist assessment arranged in relation to their mobility and the deputy manager was talking to the GP in relation to the results of some blood tests people had. We saw other people had involvement from the occupational health, podiatry, the dentist and GP. Staff told us that each person's health needs were being reviewed and we saw dates had been booked in to do this.

One relative told us staff always showed concern or called the doctor if their family member was unwell. Another said they were updated regarding any health concerns. People were supported by external healthcare professionals. For example, one person was at risk of choking and had been referred to the Speech and Language Therapy team (SALT). Essential guidance was clearly displayed for staff to follow.

Inadequate

Is the service caring?

Our findings

Staff did not show people they mattered. There was a board in the dining room that had the wrong information on it. It still had the previous weeks menu details on. Staff were not engaged with people and the home functioned in an institutionalised way. It did not feel like people's permanent home. Whilst people were given the basic care they needed and their basic needs of warmth and clothing were met staff had made no attempt to make the premises feel homely. The home was sparse with no pictures of people around the home, and no pictures of people taking part in activities. Staff referred to it as a, "Ward" and the people living there as, "These people" as though they were a group of people who were different. There was no collective aim from staff to provide clean, welcoming, well maintained premises which people could call their home.

People were not always shown compassion or support by staff. We heard one person become quite distressed during the day and showing signs of anxiety, however staff 'called' to them through a locked door, rather than engaging with them to help calm them down. Another person also appeared to be anxious. Staff told us this was partly due to our presence and partly due to the front door being locked in the morning as workmen were in the grounds. Both of these people were repeatedly pulling the inspectors and staff members around the building trying to access locked rooms. On several occasions staff walked in the other direction and did not respond to the situation for example, we saw people banging their heads against the doors and the locked gate but staff did not act or intervene. Although staff appeared caring, some did not demonstrate they had the competency to support people to reduce their anxiety and meet their needs.

People were not treated with respect. During the lunch time we saw people sitting at dining tables which were attached to the wall leaving only two of the four sides available. This meant everyone was sat facing the wall and with no room for staff to sit and join them. Staff were walking up and down the dining room and giving instructions or standing over people watching them eat. This led to the feeling they were 'patrolling' the area which did not create a relaxed atmosphere. One relative told us, "They (staff) stand over people when supporting them to eat." We asked staff why the tables were not pulled away from the wall so people could sit around them and were told it was because one person would up-end the tables and another would unscrew the bolts used to secure them to the wall. However, we saw other tables in the building which were not secured to the wall. Staff did not interact with people. We heard staff discuss amongst themselves what people were enjoying during lunch, but there was no positive engagement or conversation with people.

People's were disregarded or ignored by staff. One person tried to access the kitchen as a staff member was closing the door as they wished assistance from staff. The staff member agreed to help this person in order they could shut the kitchen door but then continued with other tasks and ignored this person's further requests.

People's dignity was not upheld . On the first day we saw one person had an infection on the back of their hand. This person had a habit of taking people by the hand to show them what they wanted. We asked staff about the potential risk of cross infection and were told, "We were only discussing this the other day, what to do about it as it is a real concern." But no action had been taken. On the second day we found there was no running water for people to be able to wash their hands after using the toilet and only one had a working hand-drier. We asked the deputy manager about this. They told us there must be a fault. However later on they told us (after checking with a member of care staff) they had been turned off at the wall to stop one person, who had restricted fluid intake, from drinking the water. They said that when they saw people going to the toilet they were able to turn them back on so they could wash their hands. Bathroom doors were locked and we were told this was because people did not wash their hands properly and, "The water splashes back at them so the floor gets covered in water." They added the toilet near the main entrance was always unlocked and people could access this. We did not find this to be the case and it was unclear why this did not pose the same risk. On the first day we saw two people return mid-afternoon from being out. They had what appeared to be food stains on their clothes. They remained in these clothes for the remainder of the day. On the second day we saw how one person had a bath following each meal which helped reduce their anxiety, however they were seen to be walking naked from their bedroom to the bathroom with no attempt made by staff to maintain their dignity.

Staff did not describe people as individuals. Staff described people by their behaviours, rather than individuals. For

Inadequate

Is the service caring?

example, “One is on restricted fluid” or, “One of them would eat the paper towels.” We noted in care plans people had written, ‘People who work with me describe me as socially active, but odd’.

The lack of respect and dignity shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there were other staff who were not so keen to get involved we did see some nice examples of caring staff. We saw one staff member touched people when they spoke with them in a caring way.

One relative said they couldn’t praise the home or the staff highly enough. They said they didn’t hear them shouting at the ‘boys’ like they used to where they were before. They told us their family member was attached to the staff and even new staff had a good relationship with them. Another relative said they were wary about their son going to Ashmount but they had settled in very well. They said, “It’s clean, warm and staff are very caring.” Relatives said they always received a warm welcome when they visited and staff were, “Very friendly” although one said that sometimes people could, “Hang on to you.”

Requires improvement

Is the service responsive?

Our findings

People did not always have access to the community. Four people went out on the bus on the morning of the second day of the inspection with two staff members. We were told they would go to the supermarket for toiletry shopping then go for a walk and a drink. However other staff told us that generally bus trips meant people would remain on the bus whilst a staff member bought refreshments and then go to a quiet park to eat them. They said people rarely got off the bus as it was not safe where there were members of the public due to people's behaviour and risk of them running off. We were told, "We don't take these guys into the community so generally go to Horton Country Park. We don't let them out of the van when there's members of the public around. A lot of these guys are absconders so have to have risk assessments and enough staff." Staff said that four people going out together was unusual, it was normally two or three people with two staff. Staff told us they found it difficult to support people when they went out due to their behaviours.

There was not enough to do for people and daily actions were described as activities. Staff confirmed this on all of our visits to Ashmount. Staff said they felt people could do with more activities. We did not see staff sit down or engage people with activities. We read in the daily log it was written, 'laundry' and 'garden' as an activity. One person's activity planner had half an hour allocated each morning for, 'combing hair'. Staff explained this was part of ensuring a, "Routine" for people. Records showed when staff put on music in the activity room they recorded it as 'karaoke' which was not reflective of what the activity was.

There were no structured activities for people who had complex needs. We asked staff if they had any games or puzzle activities when people were indoors and we were told, "No, not with these people." Staff who were on shift during the afternoon of the first day just hung around chatting. There was limited engagement with people who needed activity to stop them being bored. The home was surrounded by a large garden which could have been used for activities with people, such as planting and growing but this was not used in this way.

We saw and were told that one person had a structured routine in the mornings where they would collect litter and visit another location on the site to have a coffee. Staff members knew this routine well and understood it was important to them. However, once this had been completed there was no further activity for this person. Another person visited the same location each week at set times although there was no evidence of this in the daily activity recording.

The deputy manager told us they were trying to implement new household tasks for people so they felt involved. For example, mopping the floor or loading the dishwasher. They said a new activities plan had been developed recently and people had sessions with the occupational therapist to support them in being more independent, for example, so they could make a cup of tea or help with the cooking. They had not had time to type anything up however, so this was yet to start.

One relative told us they thought, "They (staff) could probably be more motivated in trying to introduce more activities." They said their son had previously liked to visit the pub for a drink, go out for meals and go on holiday (but this no longer happened). Another said they would like their son to go swimming.

The lack of supporting people to be involved in the community was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us some people could make simple decisions and most understood, "Simple things" for example, if they were shown two choices. But we found people were not encouraged or enabled to make choices and decisions about their care. There was no indication in care plans that people had been involved in developing their own plans. One relative told us they have never a seen a copy of their son's care plan.

Staff gave us contradictory information about people. We were told one person liked to eat paper and as a result the office door and staff room door were kept locked and all hand towel dispensers in toilets were empty. However, we saw magazines in the lounge. When we queried this we were told it was because this person only ate, "White paper." During the afternoon of the second day we saw this person eat a green hand towel from a dispenser.

There was a lack of consistent approach from staff. One person had PICA (an eating disorder) and was repeatedly trying to get into the kitchen. We saw them pushing the kitchen door when staff opened it. On three occasions they went to the drawer and removed the biscuit tin which

Requires improvement

Is the service responsive?

contained several packets of biscuits. This resulted in a 'scramble' with the staff member on two occasions. On the third instance a different staff member got them a plate to sit and put their biscuit on although they had already eaten four biscuits.

Another person had eaten something they had picked up from outside. They were encouraged by staff to spit this out and we saw them repeatedly indicate to staff they wished to brush their teeth. A staff member told us they were prescribed toothpaste from the dentist which could only be used twice a day and they carried a packet of mints to give to them if they got too anxious. However this was not a plan followed by all staff members.

Information relating to people's care was not readily available. On the first day when we asked staff if they'd seen people's care plans we were told, "Not today, haven't seen it. Today I am just being told what to do verbally. Most things I have to ask." Staff were unable to find care plans for us on the second day and did not have a sufficient working knowledge of RIO to show they knew where to find information about people or how to record daily notes. Handovers were verbal conversations between staff. The deputy manager told us daily notes were updated three times a day however, they had been without access to RIO for six weeks. The nurse on duty in the afternoon said that key nurses for individuals had access to health action plans for people, but care staff told us they did not. On 7 August 2015 we were told by staff that everyone had been booked for a clinical review which would help to ensure all clinical information was current.

Care plans were out of date and incomplete on our visit on the second day. The two care plans staff did find contained some information which had not been updated since 2012. One person had health issues and required regular blood tests, but the last entry to show this had been done was 18 months ago. Information about this person's homely remedies (medicines that can be obtained without a prescription) and their hospital passport were last reviewed in April 2014. One person had in their care plan, 'start a sleeping chart' but we could not find evidence of this having been done. Progress notes and clinical appointments were not recorded logically but noted within the daily progress notes. Although staff told us the daily notes were logged onto RIO they were unable to demonstrate to us how to retrieve this information.

On 7 August 2015 staff told us they had found all five care plans and we saw these contained up to date information about people. This included people's conditions, how it affected them, signs and behaviours and what they meant, communication, support needed and preferred activities. Although these were much more comprehensive than we'd been previously shown there were still gaps. For example in relation to people's health appointments.

Information and guidance to staff was not available in everyone's care plans. One person had a 'positive and proactive support plan' in place which included diffusion guidelines for staff and ways to respond to particular behaviours. This was being piloted with a plan to roll out to everyone by the end of September 2015. This is important information which we would have expected to have seen in all of the care plans.

The lack of good record keeping was a breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew how to make a complaint. We were told by the deputy manager that there was currently one formal complaint being handled by the provider, but no other complaints had been received. Relatives confirmed to us they knew how to complain.

Inadequate

Is the service well-led?

Our findings

Robust record keeping systems were not in place in the home. On the second day of our inspection staff were unable to provide us with all the care records for people. We found two care folders in amongst other paperwork in a filing cabinet in the managers office. One staff member told us care plans were stored in people's rooms, but another said they were held in the staff room. We found one care plan we were given had the front cover of the folder missing. We were told by staff that the other three care plans had been destroyed by one person who lived in the home. There was an agency nurse leading the afternoon shift who was not clear on how to access all records.

Quality audits were carried out on the home by senior management but improvements were not always made. We read 'board walks' were held by directors and non-executive directors. We read the May board walk noted agency staff had had to be used, the environment was clean and tidy and staff would recommend the service. It was recommended an improvement would be to, 'maintain a regular staff team'. The February board walk noted the home was clean and tidy, but sparse, health sections in care plans were not dated, some staff said morale was low and staff felt more activities and opportunities for people to go out was needed. It was recommended more, 'regular staff was needed'. Despite both audits identifying the need for a regular staffing team, we identified during our inspection this was not always happening.

In-house audits were carried out to measure the quality of the service but actions not always addressed. We saw an annual risk assessment was carried out in October 2014 and a health and safety audit in June 2014. The most recent infection control audit (March 2015) identified a need for all staff to receive refresher training, blinds in people's rooms were dusty, the conservatory had 'black old dust and debris', the glass roof needed cleaning, the soap dispenser on the washing machine was broken and the yellow waste bin was rusty and the foot pedal broken. During our inspection we noted many of these actions had not been completed.

Relatives and people were not always involved in the running of the home. At our inspection on 10 July 2014 we found a breach in assessing and monitoring the quality of service provision. This was because people and their representatives were not asked about their views on the service they received. After the inspection the provider told us they would organise quarterly weekend meetings for family members to attend to formalise the feedback from families. One relative said they had not received a satisfaction questionnaire since their son had moved in.

The continued lack of robust governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not supported by the Trust. We found during our inspection on the second day, the deputy manager (who was new to the post) was left in charge of the home without support from senior management or experienced staff. They were unable to tell us why the registered manager was not at the home and could not answer many of our questions, or provide us with information we required as they were, "Still learning." For example, they could not show us MCA or DoLS records, all care plans, daily notes, meeting minutes, training records, risk assessments or cleaning schedules. The deputy manager did not know how to access other senior staff to support them with our inspection. They did not know which numbers to phone. On 7 August 2015, we were shown an action plan which responded to our earlier feedback. This addressed the environment, supervisions, appraisals, staff training, staff access to RIO, staffing levels and care plan reviews. Timescales for completed actions varied between immediate and the end of 2015. We were told an Ashmount daily recording audit form had been reinstated in June 2015. We noted some of the actions had already been completed.

There was a lack of organisation on the second day which meant the home would be vulnerable and at risk during an emergency. Staff did not have direction and there was a lack of knowledge about people from the deputy manager who had only been at the service for six weeks. We were told the information they had was given to them from other staff and they were unclear how to access records on RIO.

The lack of support for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager was present on 7 August 2015 as well as a Trust manager. They were able to show us they knew how to access all information, answer our questions and describe what work they had already undertaken to improve the care for people. We were told a 'circle of

Inadequate

Is the service well-led?

support and quality improvement plan' had been developed by senior management. This included daily, weekly and monthly monitoring, weekly one to one meetings with the acting manager and deputy manager, daily audit visits and all staff to receive one to one's to identify training requirements. In addition a new process for contacting senior management had been introduced.

Staff felt they worked well together as a team. One staff member said, "We all have our individual skills." They said they felt supported by the manager, but had little to do with senior management. They told us they felt supported by the acting manager, but did say she was very busy and it was a big job. They added they were pleased there was now a deputy manager to help out. Staff said they had started having staff meetings every month which were really useful.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured appropriately deployed staff.** **The registered provider had not ensured staff were supported.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The registered provider had not ensured the premises were a suitable place for people to live.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had not ensured they followed current legislation in relation to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured people were treated with dignity and respect.** **The registered provider had not ensured people were supported to be involved in the community.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not ensured people were provided with care and treatment in a safe way and responsive to their needs.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not ensured robust governance processes were in place. The registered provider had not ensured good records were held at the service.