Resicare Homes Limited

Ashton Lodge

Inspection report

Ashton Road
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01 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 31 August and 1 September 2017.

Ashton Lodge is registered to provide care to 54 people some of whom are living with dementia and long term conditions. The accommodation is set over two floors. Originally an old school, the building has been extended over the years.

There was not a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was considering applying to become the registered manager. We will be monitoring this. The provider was present at the home and working with the acting manager. Another manager from one of the providers other homes was also present, supporting the service.

At this inspection we found seven breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

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

We brought the inspection forward due to a substantiated safeguarding concern.

People did not have robust and clear risk assessments in place which identified the risks which they faced, with a plan for staff to follow to mitigate these risks. The provider was aware of this issue and there was a plan to re-write these documents. However, this issue was raised at our last inspection and action to improve these documents had only just started.

The staff had a good understanding about how to protect people from potential abuse and harm. However, the existing management team did not have a full understanding about when certain safeguarding events, should be reported to the Local Authority and CQC.

We identified some concerns with potential infection control. Staff were not always following safe and appropriate practice to prevent the spread of infection. There were times when we identified hygiene issues in the communal bathrooms.

There were various safety checks which the service was completing in relation to ensuring the equipment within the home was safe to use. However, the service did not have an effective emergency plan in place for staff to follow, if there was an emergency within the building. Recruitment checks for staff were also not fully robust.

Documents and records were chaotic and often had information missing. Therefore we could not be confident that 'accidents', 'incidents' and people's needs were always being responded to appropriately and in a timely way. The provider was aware of this issue, but there was no concrete robust plan in place at present to address this.

There were good levels of staff supporting people at the home. However, staff were not always effectively deployed, managed, and trained. Staff competency was not being routinely and robustly checked or monitored. Staff did not receive regular effective training in areas such as dementia care, or in conditions relevant to the people they were supporting.

Staff said they felt supported by the management team at the home and said they had regular supervisions and a good induction.

The Care Quality Commission (CQC) is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and reports on what we find. The service was working within the principles of the MCA. Staff had a good understanding about the need to seek consent from the people they were supporting.

People were not being supported to have choice with their food and drinks. People were not involved with the planning of what they ate and drank. Techniques to encourage people to make informed choices with their food were not being used. Staff sometimes rushed people they were supporting to eat. There was no regular review from the management of the home about people's dining experiences and if people liked the food and drinks provided.

Staff were not consistently caring towards people. They did not always treat people in a kind and respectful way. Staff were sometimes short and direct with people. Staff did not always respond when people needed support. People's confidential and sensitive information was not always protected.

People did not have personal care assessments, care plans and reviews which were relevant to them as

individuals. People's backgrounds and interests were not fully explored or identified by the service. The service did not try to match the social opportunities provided at the home to what people found interesting or enjoyed. There was a lack of social engagement from staff with people at the home; staff felt they did not have time to do this. There were no planned events or outings at the home. People did not engage with the activities provided. There was no attention or consideration given to look at ways to address this issue at the home.

The provider had not been completing audits or any thorough quality monitoring checks at the home. There was no current system to ensure this would take place in the future.

There were no robust systems in place to ensure people's needs where regularly met. The management team were not completing routine quality monitoring checks. Systems to ensure accidents and incidents were addressed fully, were only just being developed. Improvements were being made to the service, but robust quality monitoring systems had not been put in place.

The staff spoke positively about the acting manager and the provider and had confidence in their leadership. The provider was working closely with the Local Authority to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not have robust risk assessments with guidance for staff to follow.

The leadership of the home was not always identifying safeguarding concerns and reporting them to the Local Authority.

Safe practice with infection control was not always followed by staff.

Staff had a good understanding about how to protect people from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported to have the skills and knowledge to meet everyone's needs.

The service did not promote choice with people's food and drinks.

Training was not always robustly provided to enable staff to effectively meet everyone's needs.

The service was compliant with the mental capacity act.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff approach was not always caring and kind.

Staff were not always respectful to people.

People's confidential information was not always stored securely.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive consistent care relevant to their care needs.

The service had not assessed people's needs in a robust way. People's needs were not being reviewed in a meaningful way.

The service was not exploring and making efforts to meet people's social needs.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to monitor the quality of care provided.

Systems in place did not guide staff to ensure good practice was consistently provided.

There was limited effective consistent leadership of the service.

The provider had not conducted regular and thorough audits of the service.

Improvement plans were in place and some action had been taken.

Ashton Lodge

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.

The inspection took place on 31 August and 1 September 2017 and was unannounced. The inspection was carried out by two Inspectors and an Expert by Experience. An expert by experience is a person who has experience of this type of care service.

Before the inspection we viewed all of the information we had about the service. The acting manager had completed 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. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority contracts team and the local authority safeguarding team to ask for their views on the service.

During the inspection we spoke with fifteen people who used the service and five relatives. We spoke with seven members of staff, the acting manager, provider, chef, activity co-ordinator, and a visiting health professional.

Requires Improvement

Is the service safe?

Our findings

We inspected Ashton Lodge in June 2016 and found there were areas relating to people's safety which required improvements to be made. When we visited the home in August 2017 we saw that some improvements had been made. However, we also found that improvements were still required, to ensure people were safe.

People did not have full risk assessments which identified clearly all the risks which they faced. There was no clear guidance for staff to always follow to ensure that staff consistently met people's needs in a way which mitigated these risks. For example we were made aware that two people had experienced a breakdown to their skin. There were no clear plans in place for staff to follow to meet these risks. We also asked some members of staff about these people's skin care needs and two members of staff believed these people did not have a current breakdown to their skin. A further person was at risk of choking. Their risk assessment identified this as a risk but there was inconsistent and unclear guidance for staff to manage this risk.

The provider had spoken to us about the current condition of people's risk assessments. They told us and showed us the improvements they were making to address this issue. They told us that everyone living at the home would have detailed risk assessments with clear plans for staff to follow. However, this had not been implemented at present, and there was no detailed plan for when this would be completed.

The service did not have a robust contingency emergency plan in place. We were shown a plan which was not clear to follow and lacked detail. It stated if there was a need to suddenly evacuate the building people would be moved to the provider's other two homes. We asked the provider what would happen if these homes were full. The provider told us that these homes had large communal spaces and if they could not accommodate everyone they would look to accommodate people at the homes of members of staff. At this point they said the Local Authority would be contacted. This showed that a meaningful and realistic plan had not been considered with clear guidance for those in charge to follow in case the provider was not available.

During our two day inspection we observed staff leaving people's rooms on four separate occasions holding used continence products. Three out of these four times staff were wearing gloves and aprons. On one occasion a member of staff was not wearing a pair of gloves. We also observed a member of staff leaving a person's room after assisting this person with personal care. They also left the room still wearing gloves. We entered another person's bedroom as a member of staff was leaving the room still wearing gloves. They had just supported another person with their personal care needs. We found dirty tissues on the floor, we later returned to this room and the dirty tissues were still on the floor. We visited one person's room and found one of their prescribed creams had brown staining on the packaging of this product. It had not been removed.

We entered a communal toilet which had a bin to dispose of used continence products in it. We noted it was full and there was a strong odour in the room in the late morning. We returned to this room in the late afternoon and it had not been emptied. Someone had sprayed a deodorant to mask the smell. During our

visit we entered a communal bathroom. We noted there was a soiled pair of underwear in a linen trolley with used towels in it, in full view. The toilet had been recently used and faecal matter was around the inside of the toilet. We understand that a person may have just used this bathroom. However, before we entered we saw a member of staff enter and then leave the room; they had not identified and addressed these issues. We entered this room again later in the day and found a similar situation. Staff had been entering and leaving this room to assist people, but these cleanliness issues had not been addressed.

At the previous inspection the home had been criticised for the general cleanliness of the communal rooms and people's bedrooms. At this inspection we found that the communal spaces and bedrooms were clean. We observed 'domestic cleaning staff' cleaning throughout the home during our two day visit. However, we noted a large table in one of the lounges was so sticky; a member of staff had to use real force in order to lift a tray with jugs of juice from the table.

During our visit we completed an audit of people's medicines. We looked at a sample of seven People's medicines and looked at these people's Medication Administration Records (MAR). We found that six people out of the seven had received all of their medicines as the prescriber had intended and these people's MARs had been completed correctly. However, we found that one person had not received one of their prescribed medicines the day before. We advised the provider about this.

We observed a senior member of staff administering some people their medicines. They walked away from the medicine cabinet without securing it. Instead they asked a member of staff to "Look after" the opened medicines trolley while they left the room. This is not appropriate practice when administering medicines.

The service was not storing people's prescribed creams in a safe way. We found three people's prescribed creams were being left in their rooms. These needed to be stored at a particular temperature otherwise these medicines may not be effective. These people's rooms were not being checked to ensure these medicines were being stored within the safe recommended temperatures.

People's medicines were being stored in locked trolleys placed in the communal spaces in the home. Staff were recording and monitoring the temperatures of these trollies. We looked at the records for four medicine trollies. These records showed that the trollies were regularly getting close to the maximum recommended temperature. We spoke with the medication coordinator who told us that staff were to place these trollies in an empty bedroom with fans on. If the trollies reached the maximum recommended temperature. We asked what would happen if the home was full, we were told, "That would be a problem." Considering these trollies were regularly getting close to this recommended temperature, there should have been a long term plan in place to appropriately address and resolve this issue.

We also found that one person's prescribed product, to prevent them from choking was left unsecure in their bedroom. If this is accidently ingested without the correct amount of fluid this could cause a person to choke. We were aware from recent historical concerns that some people who were living with dementia had entered other people's rooms. Therefore this item needed to be removed. We advised the acting manager about this. Once we had explained why it should be removed, they told us it would be removed immediately.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we noted numerous staff supporting people. We were shown the last four weeks staff rotas; these reflected the amount of staff on duty when we visited the home. Both staff and people felt there was

enough staff to meet people's care needs. However, we observed there were times when there was a lack of staff presence in the communal rooms. At these times people did require assistance and support. We also observed that in the communal lounge, where people who were living with more advanced dementia spent most of their time, there was insufficient numbers of staff when assisting people with their lunch. We observed staff talking in groups, completing paper work together, not in full view of the room. We also heard a member of staff asking another member of staff if they could go for another cigarette. The other member of staff said, "But you've just been out…Oh go on then." We concluded there was an issue with how the care staff were being managed and deployed, not the number of staff on duty.

People were protected against the risk of experiencing harm and abuse. The staff we spoke with had a good understanding of how to identify if a person was potentially experiencing harm in some way. Staff talked about a person presenting as withdrawn and not themselves as a possible indicator of experiencing harm. The staff we spoke with said they would report any concerns to the acting manager or provider. All the staff we spoke with were also aware of the outside agencies they could also report their concerns to, such as the local authority safeguarding team. One member of staff pointed to where the telephone number was for this team, when we asked how they would contact this team.

However, we looked at an incident which had occurred between two people who were living at the home. Both parties had experienced harm in some way. Both parties we were told were living with dementia and lacked insight into the situation. This should have been reported to the Local Authority Safeguarding team. We asked the acting manager about this case, they had not identified this event or type of event as a safeguarding matter. We were also told about a person who had a severe breakdown to their skin, due to the level of this skin breakdown, this should have also been reported to the safeguarding team.

During our visit we spoke with one person who told us that the service kept losing their property. They said, "They keep losing my clothes. They take them off to be laundered and my clothes never come back. Nearly all the clothes that I came in with have now been lost."

The above concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment checks were not always fully completed to ensure staff were suitable to work in a care environment with vulnerable people. The Disclosure and Barring Service (DBS) checks were in place. People's identities were verified as part of this process. However, out of the three staff personnel files we looked at, the service only had one proof of one member of staff's identity. We also found that not all these members of staff had full employment histories with gaps explained. These are all important checks to demonstrate that the service is taking every step to ensure those employed to work in a care home are suitable and safe to do so.

We were shown various records of safety checks a person employed by the service was completing on a regular basis. Fire equipment was being checked to see it worked on a regular basis and there were evacuation drills taking place. The service was testing for the bacterium Legionella. This can grow in water supplies and can cause people to become unwell. Equipment to support people to transfer from one position to another was being tested yearly. Electrical items in people's rooms were also being tested yearly. However, we found some electrical items in people's rooms which had not been tested to ensure they were safe to use. We addressed this with the acting manager. We also found that there were no regular tests taking place to ensure specialist mattresses, to help prevent people developing a breakdown to their skin, were working.

People told us that they felt safe around staff and living at Ashton Lodge. One person said, "Yes I feel safe here. Much better than my previous home I lived at." Another person told us, "Nine out of ten." A relative said, "I feel [relative] is safe here and cannot wander off. There is a beautiful secluded garden which is walled in. [Relative] is safe here we spend hours in this garden together."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in June 2016 the service was found to be good at providing effective care to people. However, at this inspection in August 2017 we found that the service needed to make improvements in this area.

We found that there was a lack of checking and testing that staff were competent in their work. The management team had not and was not completing spot checks when staff were carrying out their duties. The staff we spoke with said they did not receive feedback about their work. We noted that there were times when staff practice was not consistently effective. This related to hygiene and infection control. We observed staff assisting people to transfer from one position to another. It was noted these were safe transfers. However, we noted that staff regularly knocked the transfer equipment against people's chairs, when preparing to transfer them. We also observed a member of staff administering medicines to people without using the appropriate equipment.

During our visit we looked at people's daily notes. Some people's food and fluid intake was being monitored because they were at risk of losing weight. Some of these records were not being completed on a regular basis. We looked at the computer record of a person who was at risk of unintentional weight loss. Records showed that staff were not consistently recording the persons fluid and food intake. It was unclear from looking at some people's paper and electronic records whether staff were responding to a change in people's needs when their needs changed.

Staff told us that they did not have time to read people's care assessments and care plans in order to get to know people and their needs. One member of staff said, that they would have to come in on a day off to read these documents. They told us about a person who presented as non-communicative. They did not know this person could actually communicate, until this was mentioned by another member of staff.

This showed that staff lacked the training, skills, and support to complete important documentation relevant to people they were supporting and therefore were not always aware of how best to support people.

The above concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about the induction process. One member of staff said, "The induction was only two days and this was my first job with care of the elderly." Other members of staff told us that their inductions were effective and prepared them for their new role. Most staff said they shadowed experienced staff for a week before they worked independently. One member of staff told us, "It [induction] was about two weeks before I was let lose." We saw records which showed that staff competency had been signed off at the end of their induction. However, these records did not demonstrate if staff had a good knowledge and understanding of people's needs. It was a list of tasks with ticks next to them. The record did not evidence

that staff practice had been robustly observed and checked.

Staff told us that they received training on safeguarding, mental capacity, first aid, fire safety, and moving and handling, during their induction. When we looked at a sample of staff personnel records we saw documents confirming this. However, two members of staff felt the training relating to moving and handling did not go into enough detail.

We asked the management team to show us the yearly training programme for staff. This document showed that staff had had up to date training. However, despite recent training in infection control this training had not improved the day to day practice of staff in this area. It stated staff also received training in dementia care. Again this was not consistently evident from our observations. Considering that a proportion of people at the home were living with dementia, the service did not have a clear focus on dementia care. There were other people who were living with other long term conditions and staff did not receive training about these conditions.

When we spoke with people about the food and drinks, we had mixed views about the food provided at the home. One person said, "I feed myself and I really like the food here. I have plenty to eat." Another person said, "I like the food. They more or less make me the meal I request." However, we spoke with one person after they had finished their lunch; we asked them what they thought about it. They said, "Alright, if you like plastic ham." Another person said, "its always cold…Sunday lunch looks like it is all mashed together."

We looked at a sample of people's care records who had specialist dietary needs. The chef was able to tell us what these people's dietary needs were. They showed us a list which they said was updated by staff on a regular basis. However, when we looked at people's care records it wasn't clear if staff were always following the guidance given by specialist health professionals, in relation to people's needs who were at risk of choking. For example, staff told us that one person should be on a soft diet, others said pureed, but when we looked at their food chart they had eaten biscuits and sandwiches on a regular basis. The advice from a specialist health professional in 2016 was that this person should be on a soft diet. Referrals had been made to specialist dietary teams. However, it was not clear from speaking with staff and looking at people's care records, what the most up to date information was about people's dietary needs.

During our inspection we observed staff supporting people who needed assistance to eat and drink. We observed one member of staff spending real time encouraging one person who was living with advanced dementia, to eat their lunch. However, we observed other individuals being supported to eat at a rushed pace. On occasion staff were out pacing individuals. One member of staff was supporting two people to eat who were sitting next to each other. This member of staff gave a mouthful of food to each person simultaneously until they had both finished.

We noted that people in this room were not being regularly encouraged to drink. One person had a cold glass of tea in front of them, this was not removed, and a warm one supplied. People were not given a choice of juices. One person said, "Can I have a cup of tea." A member of staff said, "You've just had one sweetie."

People were not involved in making decisions with what they wanted to eat. The service had not obtained a clear understanding of people's likes and dislikes relating to food and drinks. People were making a choice from the menu however; they were not consulted with when the menu was being devised. We were told that an employee, who worked across the providers three services, chose the menu based on their experience of what they thought people liked. There was no efforts made to also involve people who were living with dementia about what they wanted to eat. Techniques such as platting up two choices or pictorial menus

were not used. We saw one member of staff encouraging a person who was living with advanced dementia to eat their pudding, eventually the person shouted, "I don't like it." We saw another member of staff saying, "Oh she doesn't like Angel Delight, but try it anyway." The chef told us that they tried to speak with people about the food, when they were on a break. This had not been incorporated as part of their role.

There was no attention made to make the dining experience pleasant. We saw that when staff supported some people to eat they did not communicate with them or try and have a conversation with them. We saw one member of staff who supported one person who required a soft diet, stand over the person and mix the food together on their plate before they assisted the person with this meal.

Some people required their food to be pureed because they were at risk of choking. This food was not separated it was piled on top of each other. We spoke with the chef who told us there were no plans in place to make pureed meals more appetising. Considering that there were people who lived at Ashton Lodge who were at risk of being under weight and at risk of not having enough nutrition. The dining experience had not been considered as a stimulus to encourage eating and hydration.

The above concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The people who we could communicate with told us that they were offered choices with elements of their daily lives. Such as when they went to bed and the support they were given with their personal care needs. The staff we spoke with told us that they encouraged people to make choices day to day. These members of staff who we spoke with also had a good understanding of MCA and DoLS. One person was unable to leave the home and had been placed under a DoLS. We saw this person freely move about the service including the garden throughout our time at the home. We concluded that the service was compliant with MCA and DoLS.

During our visit we asked people if they were supported to access health professionals and services. One person told us, "Yes, regularly." Another person said, "Yes." A person's relative said, "All this is sorted by the care workers and this is a big relief to me my [relatives] who are jointly responsible for my [relative]." On the first day we visited there was a district nurse visiting a person at the home. We asked this professional how responsive staff were to a change in people's health needs, they said, "They [staff] are on the ball." We could see from looking at a sample of people's records that there was contact made with health professionals. On the second day of our visit we heard a senior member of staff speaking with the GP over the telephone.

Requires Improvement

Is the service caring?

Our findings

When we visited Ashton Lodge in June 2016 we found that improvements were required in some areas to ensure people received support which was consistently caring. At this inspection in August 2017 we found this was still the case.

During our two day visit to the home we observed positive and negative responses when staff interacted with people. On occasions staff were direct with people and their tone of voice was unkind. For example one person who was living with dementia had repeatedly said that they were hungry and asked when lunch was being served. A member of staff was seen standing over this person and said, "You're getting lunch in a minute [Name]." In the evening we saw a person tentatively ask when they would be getting their night medicine, the member of staff said without looking at the person, "In a minute." A person went to take their lunch outside to eat this and a member of staff raised their voice and said, "No, eat it in here."

We saw that some people had fallen asleep during parts of the day in one of the lounges and looked uncomfortable. For example one person had fallen asleep with their head on the handle of their walking stick. Staff did not support these people to ensure they were comfortable.

During our visit we noted that some communal lounges had a strong aroma of urine. Staff did not ask these people if they needed support to use the bathroom. This is not a caring approach.

Alternatively we observed some positive interactions and responses from staff. For example, we saw a person who was living with dementia who was distressed and crying. We saw two different members of staff, at different times, sit with this person, hold their hand and try and comfort this person. We also saw two people becoming agitated with one another. We saw a member of staff spend real time with these two people to support them and defuse the situation. A person began to pour orange juice over their table, another person's relative said, "You silly girl." A member of staff rushed over and supported this person. This person apologised and the member of staff said softly, "You don't need to apologies, its fine."

We asked people if staff treated them in a respectful way. We had mixed responses from these people. One person said, "Yes staff are good to me." However, some people said this was sometimes variable. Two people said "Eight out of ten." Another person said, "The staff are ok now but this has not always been the case."

There were times when staff were not respectful towards the people they were supporting. One person who was living with dementia, had repeatedly asked staff when they should go to bed. Staff had responded, a member of staff responded again, their tone was direct; the person looked surprised and said, "Oh." At this point we saw another member of staff clearly laughing about this situation. We also saw a person sitting at their chair eating their pudding which was on a table in front of them. A member of the domestic staff started hoovering around this person, under their table and around their feet, while they were eating. At times during the day we observed staff refer to people in their presence and away from them as "She," "Soft

diet," and "Feed." This was not respectful. For example one member of staff said, "Is she done?" the other member of staff replied, "Yeah she has."

The above concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they no longer held 'residents meetings' as they felt some people were over powering other people. As a result they had introduced one to one conversations with people and their relatives. However, the acting manager and provider were unable to provide any records confirming this.

We asked people who we were able to communicate with, if they had been involved in the planning of their care and support. Some people said they had been involved and others said they had not. The staff we spoke with could not tell us about people's backgrounds, their personal achievements, and who was important to them. The provider told us that they were revising people's care assessments to involve this information. However, there was no real plan in place to enable staff to get to know people and read these documents on a regular basis.

People's confidential information was not always stored securely. People's daily records were in the manager's office placed on a shelf. People's MAR charts were also not kept in a secure place. Some MARs were placed on a shelf in the communal lounge. We observed a senior member of staff prepare to administer some people their medicines. As they approached a medicine trolley, kept permanently in a communal lounge, they said. "Is the MARs upstairs again, this is really annoying me." We also saw a member of the senior staff speaking with the GP on the telephone about some people's medical needs, in the communal lounge, where people were present.

We looked at one person's paper file and found a collection of other people's and other people's relatives responses, to a historical questionnaire, in their file. We also entered a communal bathroom and found a box filled with people's daily notes. We spoke with the provider about this who said this was waiting to be archived, and no one used this bathroom. However, the door was open and the room was not secure. The provider said this box will be removed, we later saw this box in a locked room.

People's relatives told us that they felt welcomed to visit their relatives whenever they wanted to and to spend as long as they wanted at the home.

Inadequate

Is the service responsive?

Our findings

We visited Ashton Lodge in June 2016 and found the service needed to make improvements in how the service responded to people's needs. When we visited the home in August 2017 we found improvements were still needed to be made.

People did not receive consistent person centred care. People were not being involved on a regular basis in the planning and delivery of their care needs. People did not have care assessments which fully explored their risks, needs, and wishes. People's care plans did not guide staff about how to meet these needs in a way staff could access. People were not having regular reviews. Where they were being asked their views about the care and support they received and asked if anything could be improved upon.

The provider spoke to us about the quality of people's care assessments. They were aware these needed to be improved and they had started this work. Two people's assessments and care plans had been rewritten using a more detailed and person centre format. We looked at these records and found more detail was required. In order to make these records personal to individuals and to evidence people had been involved in the planning of their care.

When we looked at the existing care records we found these lacked personal detail about people's needs. One person occasionally asked staff for a cigarette. We spoke with a senior member of staff and asked them how they responded to this situation. They said, "Nine times out of ten, staff will give them one of their cigarettes." We looked at this person's care plan, and it did not mention this need with a clear plan of action to meet this need. Another person had a low appetite. With a member of the management team we looked at this person's care records. At no point during this person's long time at the service had this person's likes and dislikes of food been reviewed. Nor had the service reviewed or explored how and where this person liked to eat their meals.

Two people who had been living at the home for some time and had now reached the end part of their lives. A health professional had visited them and made this judgement. However, there was no end of life plan in place. Their wishes about how they wanted to spend this part of their life had not been explored, and put in place, to ensure these wishes were met by staff.

We were told about two people who had a significant breakdown to their skin. The service had no documentation about how the health professionals were managing this need. They were not using this information to check the progress of these people's conditions.

The provider showed us a person's recent review completed by them. We could see from looking at this review this person had been fully involved in the review of their care. However, this issue of a lack of person centred assessments and reviews had been raised at the last inspection and action was only now being taken.

During our visit we did observe some positive person centred interactions from staff. One person had pulled their top up to their ears. A member of staff said, "Shall I get you your hat?" They returned with two hats. Another member of staff commented. "Oh, you're giving choice, nice." A member of staff told us about a person's morning routine. They said that other members of staff had told them that this person always had a cup of tea in the morning. They told us how recently they had asked this person what they would like to drink, and the person answered coffee. This member of staff said they would be more conscious about how they asked people what they wanted.

However, we also saw examples of people not receiving person centred care. One person needed support to breath at times. They had tried to access their specialist equipment but could not. There were two members of staff standing near this person talking to one another. We asked them to support this person. One member of staff said, "She doesn't have that yet." We observed the situation and saw no one went over to this person to check if they were ok. After a period of time we asked this member of staff if someone had checked if this person needed support, they said they had, but they had not. We later saw this person being given their medicine. We also saw some people becoming agitated with one another on three occasions during our visit in front of or near staff. These members of staff did not respond to these situations, to prevent them from escalating.

Staff told us that they did not have enough time to engage with people in a social way. One member of staff said, "We provide good care. We have a lot to do and not a lot time to spend with people." Another member of staff said, "There is not enough staff to give one to one care, or a more personal experience."

Some people spent a lot of their time in their bedrooms. We visited a person who did not leave their room. They had been positioned facing a blank wall. There was no music or TV on and no pictures on the wall. We saw another person being supported to eat in their room by a member of staff. The member of staff did not speak to this person.

We went into one communal lounge where three people were sitting. One person did not communicate with people. They had a left sided weakness. A member of staff gave them their lunch. This person struggled to cut up some of their food and then left this item of food. No one spent time with this person to ensure they ate their lunch and was ok. Staff visited this room throughout the day to check if these people needed any support. They only spoke with the two people who could communicate. The provider visited this room and came over to this person, they gave them a pillow and helped them to reposition into a more comfortable position. They gave this person eye contact and spoke to them. This person smiled and held the providers hand. However, no other staff engaged with this person.

There was a new activities co-ordinator who worked full time and a part time activities co-ordinator. We saw there were activities in two communal parts out of the four during one day of our visit. However, people were not engaging with these activities. Conversations the activity co-ordinators had with people were stilted. Some people were completing some arts and crafts. The activity co-ordinator did not speak with any of the people completing this activity. They spent the time painting a picture.

During our first day at the home we regularly spent time in a lounge where people who were living with advanced dementia generally stayed in. A musical film was playing on a large TV on the wall. Throughout this day this film was on a continuous loop, it was played four times in total. The people in this room were not facing the TV but each other. They were not engaging with the music or sounds. Most starred at one another or slept. On the second day different members of staff were in this room. Music from the 1940's was playing; a relative was visiting and being involved in the singing. After this event people continued to chat to staff and they presented as more engaged and alert than they had the previous day.

We concluded that although this experience was positive, staff were not consistently responding to people's social needs in a meaningful way.

We were told by the provider and the acting manager that people liked to go out to the theatre and on trips. However, there were no planned events in the near future. There were no plans for social events to be held at the home.

The above concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that the service had not had any formal complaints for some time. We were shown a folder which had some complaints documented which the previous manager had addressed. We were told about an incident last year when a person's relatives had raised concerns about the care of their relative at the home. These relatives were not given the opportunity for this to be processed as a formal complaint or had a response from the service or the provider.

Inadequate

Is the service well-led?

Our findings

When we visited Ashton Lodge in June 2016 we found that the home was being well led. However, when we visited the service in August 2017 we found that the home had not been effectively managed since our last inspection.

The provider was open about the issues concerning the service. The staff we spoke with were also open about their views of the home. The provider had told us that they had made the decision to remove the previously registered manager from the service, as they were managing two large services. A home which supported a maximum of 60 people and Ashton Lodge that supported a maximum of 54 people. Which meant Ashton Lodge could not be effectively managed. However, the provider had failed to identify this issue until after our last inspection, which rated Ashton Lodge as 'Requires Improvement.' The provider had not been effectively monitoring the performance of the previous registered manager.

When we visited the home the provider told us that they were working daily with the service and restructured the management team for a period of time to address the areas which required improving. Care plans, assessments, and reviews were being remodelled. There was also a building improvement plan underway to upgrade all communal spaces and people's rooms. We could see that the improvements to the building were being put into action during our visit.

There was a lack of robust systems in place to ensure quality care was consistently provided to people living at the home. There were no strong systems to guide staff in relation to reporting, addressing, and managing a change in people's needs. There was no system in place to ensure all staff were aware about what people's needs were and how they should meet these needs. The deployment of staff was not well organised at times and people's care and social needs were not always being met by staff.

There were no effective and robust systems to monitor the quality of care provided. There was no plan or systems in place to guide the management team to quality monitor the information inputted, into these new care records. There was no member of staff or plan in place for a member of staff to routinely review and analyse how people's needs were being managed. This system would check if the service was responding appropriately to individual's needs.

The local authority had re-investigated a concern that people's nutrition and hydration needs were not always being met. This was following a ruling from the Local Authority Ombudsman in 2016. The provider had not acted swiftly to address the issues of the record keeping completed by staff, after this ruling. Systems to monitor, check, and address quality monitoring issues were not in place when we visited the home in late August 2017.

Staff practice and competency when supporting people was not being monitored and therefore issues were not being addressed with individual members of staff when these happened. There were no subsequent plans in place to support these members of staff to improve their practice. Issues with poor staff practice

with the safe administration of medicines had been highlighted to the provider by the Local Authority, when they visited to support the home. We also observed these issues when we visited. No meaningful action had been taken to resolve these issues, even when they had been highlighted. Staff were not receiving regular and thorough training to meet everyone's needs. We also identified other issues with staff approach to people's needs and elements of their practice, which the management team and provider were not aware of.

The culture and the values of the service were not being assessed, monitored, and reviewed. Staff were not being involved in this process. Staff were not being given the training, knowledge and support to meet people's needs who were living with dementia, and long term conditions. The provider was not ensuring that staff were involving and responding to everyone's social needs.

People and people's relatives were not being asked about their views of the service and care they or their relatives received. There was no community involvement or plans to involve the community in the future.

There were audits taking place with administering people's medicines. We were shown a series of records which demonstrated that regular audits were taking place to ensure people received their medicines safely and as prescribed. However, these were not always effective and thorough. There was no evidence of senior staff practice being checked when administering people their medicines. There was also no robust plan to appropriately address the temperature issue of the medicine trollies. This had not been identified as a potential concern. The provider was not checking these audits to ensure they were effective and robust.

The provider and the previous management of the service had failed to monitor, identify and take action to address these issues. The provider had not completed thorough and regular audits of the service to check it was being managed effectively. The provider had not taken swift action when issues with the care people received were highlighted to them.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the local authority who told us that the provider was working closely with them to make improvements. However, the changes being made had not addressed all the issues we had found during our inspection.