KYS Limited

Ashleigh House

Inspection report

8-9 Westminster Road
Earlsdon
Coventry
West Midlands
CV1 3GA

Tel: 02476228200
Website: www.ashleighcarehome.com

Date of inspection visit:
14 November 2016
20 December 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 November 2016 and 20 December 2016. The visit was unannounced. Ashleigh House provides care and accommodation for up to 24 older people. At the time of our visit there were 17 people living in the home.

The home is required to have 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. There was a registered manager at the time of our previous inspection in September 2015, but they left the service in September 2016. There was a new manager in post that was not registered with us.

When we inspected the home in September 2015 people told us that some staff were not caring in their approach and people were not fully involved in decisions about their care. There were limited activities that met people's needs and wishes. As a result, we rated the home as 'requires improvement'. At this inspection visit, we looked to see if the provider had taken action to address the issues we had identified. We found improvements had been made in relation to caring but they were ongoing in relation to responsive. In addition, this inspection found improvements were needed in regards to "safe" and "well led".

At times there was no senior staff members available in the manager's absence to ensure the ongoing safe and effective management of the home. This was because there was only one senior care staff member employed to cover shifts in the absence of the manager.

Where people were at risk of poor health, due to not eating or drinking enough, there were processes to monitor their food and fluid intake to help ensure their nutritional needs were met. However, records were not always clear to show instructions given by health professionals were followed.

Risks associated with people's care and support needs were not always managed in a consistent way. This included risks associated with the use of specialist equipment, management of accidents and incidents and medicine management.

Accidents and incidents had not been reported to us consistently as required to ensure appropriate actions were taken to keep people safe. This included incidents of a safeguarding nature. Some policies and

procedures had not been updated or made available to staff to ensure they were aware of their responsibilities.

Staff knew how to recognise potential abuse and understood their responsibilities to report this to the manager. However systems and processes to follow to refer abuse to the relevant external agencies, and ensure information was sufficiently recorded, were not clear for staff to follow in the absence of the manager.

Overall people received their medicines as prescribed but two medicines were identified to be used beyond the dates they should have been.

People told us they felt safe living at the home because they were treated well by staff. People said staff were respectful towards them and we saw caring interactions between staff and people. Staff members were mindful of protecting people's privacy and dignity and people told us staff asked them before supporting them with personal care.

People said they had enough to eat and drink and there were meal choices provided each day.

The provider carried out a range of recruitment checks before staff started work to ensure staff employed were safe and suitable to work with people. There were sufficient numbers of staff employed to meet people's basic care needs but some people had limited support in relation to pursuing their interests, hobbies and outside visits.

Staff completed training on an ongoing basis to help them develop their skills and competence to carry out their role safely and effectively. Staff told they had supervision meetings with the manager to discuss any ongoing training needs. Further training was being sought in specialist areas such as dementia care.

Staff had received training in the Mental Capacity Act and had a basic understanding of the principles. The manager had submitted applications to the supervisory body (the local authority) where restrictions had been placed on people's care amounting to a deprivation of their liberty.

Visitors were made to feel welcome at the home at any time to help people maintain relationships with people important to them. There was a relaxed atmosphere in the home for people but staff were busy throughout the day completing their duties.

Complaints received had been responded to, and people knew the staff to approach if they wished to make a complaint. However, the complaints procedure was not up-to-date to ensure people knew how to escalate their concerns further if they wished.

Each person had a care plan which contained information staff needed to meet people's care needs. Most people said they were not involved in planning their care but the manager said processes were in place to involve people and ensure they received person centred care in accordance with their needs and preferences. People had access to some social activities to support their interests and work was ongoing to further improve these.

There were systems to monitor the quality of the service and drive improvement within the home. Satisfaction surveys had been completed by some people with mostly positive results.

People and staff told us the manager was approachable and staff were complementary of the support they

received from the manager. The provider was available in the home on a regular basis and staff and the manager felt supported by the provider.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009.

You can see what action we have told the provider to take at the end of this report.

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 consistently safe.

There were sufficient numbers of staff to meet people's basic care needs but senior staff were not always available. Staff understood their responsibility to report concerns related to people's wellbeing to their manager. There were some practices associated with medicine management that needed to be improved. Processes to manage risks, accidents and incidents were not always effectively managed to ensure people's ongoing health and wellbeing. Recruitment processes ensured staff were safe to work with people.

Is the service effective?

Good

The service was effective.

Staff completed training on an ongoing basis to help ensure they had the right skills and knowledge to support people effectively. Staff understood the principles of the Mental Capacity Act (2005) and the need for people to make their own decisions where possible. Where restrictions on people's liberty had been identified, applications had been made to the supervisory body. People were supported to attend appointments with external healthcare professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were caring and respectful in their approach. Staff understood the importance of respecting people's privacy, dignity and independence where possible. People were supported to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People felt they were not always involved in planning their care. People were given opportunities to participate in some social

activities within the home and work was ongoing to develop these further. Care plans were subject to ongoing review to ensure they were person centred and provided staff with enough information to support people's needs and preferences. The complaints procedure was not accessible or up-to-date but people knew staff to approach if they had any complaints. Those received by the manager had been acted upon and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Overall people were positive about the home. Quality audits and satisfaction surveys were used to monitor the quality of the care and services provided. However, processes and systems in place were not fully effective in ensuring safe practice and the quality of service was maintained. Statutory notifications regarding incidents and accidents in the home had not been reported to us consistently as required.

Ashleigh House

Detailed findings

Background to this inspection

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

Our inspection visits took place on 14 November and 20 December 2016 and were unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioning officer to find out their views of the service. The information they shared was similar to what we knew about the service in regards to improvements needed. This included the service being able to maintain social activities for people in accordance with their interests and preferences. We looked at the last visit report completed by Healthwatch on 24 February 2016 so that we could see if any of their recommendations had been implemented.

Before the inspection, the provider 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. This however, contained limited information in respect of the information we requested to support the inspection process.

We spoke with six people who lived at the home, two visitors, three staff members and the manager. We observed the care provided to people and reviewed the care plans of two people in detail. We also reviewed other records to demonstrate the provider monitored the quality of service such as staff training plans, quality monitoring questionnaires, audit checks, accident and incident records, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care were not always managed effectively. For example, there was no specific risk assessment or procedure to follow in regard to moving and handling a person who would need specialist equipment to move them safely should they fall or require increased assistance. This equipment was not available in the home. The person had been assessed as low risk of falls but this was because the person did not walk much due to them experiencing pain and discomfort in their legs when walking. At the time we identified this concern, there was no falls policy to guide staff on what to do should people fall. We discussed this with the manager and a falls policy was developed by the second day of our inspection. However, we noted this contained information such as taking temperature, pulse, blood pressure which are usually actions a health professional would take as opposed to care staff. This suggested the policy had not been developed specifically for staff at Ashleigh House in relation to the people they supported.

We found the approach to managing incidents within the home was not always consistent. Shortly after the second day of our inspection, we were notified by the Local Authority there had been an incident involving a person that had resulted in a serious injury. This had not been reported to the required agencies including ourselves which meant, at the time, we had been unable to check what action the provider had taken in response to this. This person was known by staff to require close monitoring to minimise the risk of them falling or coming to harm. Staff were required to complete hourly checks to maintain the person's safety. Records showed the hourly checks were not completed consistently to minimise the risk of falls and injury. We also noted an entry in the daily notes which said the person was assisted by staff at 3am but in the hourly checks records for the same period, stated the person was asleep. These entries conflicted with one another and we therefore could not be assured the information regarding hourly checks of people was accurate to ensure the person's safety and wellbeing.

When we looked at records for a person who was at risk of not eating and drinking enough, we could not tell whether the person's food was fortified (calories added such as cream, sugar) in accordance with instructions from the dietician. Information also did not confirm additional snacks were provided to increase the person's calorie intake. There were no instructions to staff in the person's care plan to help ensure this happened. Staff told us the person did not have anything different to anyone else suggesting the additional snacks were not being provided. The person's weight was being monitored weekly but we noted they had lost weight when it was last checked in November. This suggested they may not have consumed enough calories to maintain their weight and wellbeing.

Staff kept records of all drinks provided where people were at risk of not consuming sufficient fluids. However, the records did not indicate the volume of fluids each person needed to ensure staff aimed to achieve this. We saw one person had consumed 200mls of drinks on one day which was below the recommended amount people should drink. An additional 300mls of fluid had been offered but it was not clear the person had consumed this. This person's care plan stated, "It is very important that [Person] maintains a good input of fluids due to being at high risk of UTI's (urine infections)." Care records showed the person had a recent urine infection.

We found some practices needed to be improved to keep people safe. Staff had received training in protecting people from the risk of abuse and understood the need to report any concerns to the manager to ensure any risks to people were managed. However, staff were not clear of the procedure to follow if they identified abuse in terms of recording this and knowing the agencies to inform in the absence of the manager. We asked the manager about this and they were unable to locate a clear written procedure for staff to follow. The manager agreed to address this so that staff had access to the contact names and telephone numbers they would need to report any safeguarding concerns to in the absence of the manager, as well as be clear on records they needed to complete. Following our inspection visit we were notified by another agency of safeguarding incidents that had occurred in the home that had not been reported to us. This demonstrated the lack of clear guidance was impacting on the management of safeguarding incidents in the home that placed people at risk of harm or abuse.

We looked at how accidents and incidents were managed in the home. A record of these was kept by the manager and they told us these were regularly checked to ensure appropriate actions had been taken in response to them. However, the checks did not include analysis to identify patterns and trends such as times they occurred, the location and staff on duty etc. This meant risks may not always be fully identified and addressed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment

People told us they felt safe living at Ashleigh House because they were treated well by staff. One person told us, "They treat us very well, I feel really safe here." Another told us, "I'm alright here, safe enough. The staff are nice enough people I think, I feel quite happy with them."

The manager told us they assessed risks associated with people's care prior to them coming to live at Ashleigh house and assessments were in place. Assessments included information such as any support people needed to mobilise so they did not fall and information on special dietary needs such as soft diets to prevent the risk of them choking. This information was transferred into care plans with instructions for staff to follow to minimise any risks identified and ensure their needs were met.

Staff were aware of some of the risks associated with people's care. For example, they explained about a person who was reluctant to move from their chair which placed them at risk of developing sore areas on their skin. The staff member told us, [Person] is assisted to stand from the chair and encouraged with continence to prevent further skin breakdown." They also explained about a person who refused to elevate their legs to prevent their health condition from getting worse. They explained the person was encouraged to do this but continued to refuse support and had the capacity to make this decision. Arrangements had been made for the person to have a specialist mattress and pressure cushion to help minimise the risks of further skin breakdown. A district nurse was also involved in the person's care to provide advice to staff as required.

The manager told us "We try to minimise the risks when identified or before identified, we look for possible risks and we put a plan in place and do risk assessments and make staff aware of action plans in case something happens." They went on to tell us about a person who had been "tripping and falling quite often" so in response to this they decided to use a "sensor mat" to alert staff when the person attempted to walk and a "crash mat" beside the bed to offer some protection should the person fall. They also carried out hourly checks of the person and ensured they were always supported by a staff member when walking.

The manager told us staff were made aware of changes in risks associated with people's care during staff

meetings. They told us, "I always make sure staff are aware of new pieces of information or risk assessments. Sometimes it's hard to speak with night staff so at times I will give them a call and tell them there is a new piece of documentation, please read it."

When we looked at how medicines were managed, we found two prescribed medicines had been administered to people beyond the timescale they should have been. Instructions for the usage of the medicines stated they should be discarded 28 days after opening. The date of opening was on the medicine boxes and the 28 days has expired but they had continued to be in used. The manager discarded them with immediate effect and located the medicines from new stock held within the home for staff to use.

Medicines were stored safely and securely and the manager carried out checks to make sure medicines were being administered and managed safely. There was a medicine administration folder and each person had their own individual records with a photograph to reduce the chances of medicines being given to the wrong person. Medicine administration records (MARS) showed people received their medicines as prescribed.

Where people had been prescribed medicines to be given PRN (as required) there were no clear PRN protocols in place stating how the medicine should be managed. For example, clear instructions to staff to prevent the risk of too many tablets being given, or them being given unnecessarily, which could impact on the person's health. Despite this, we saw staff used PRN medicines appropriately. For example, one person told us, "When my legs are bad they give me pain killers." We observed when another person complained of back pain, a member of care staff assisted the person to sit down and asked them if they would like pain relief. When they responded "yes", this was provided immediately. The manager said she would address the issue of not having clear protocols in place for PRN medicines.

We were advised that only staff who had completed training administered medicines to people. This included staff that worked at night.

Some people felt there were enough staff on duty to meet people's needs and keep them safe but at times when staff were busy; they had little time to spend with people. We identified from speaking with people they had varying experiences of being able to access care and support from staff depending on their abilities. Some people told us they were independent with some of their care so did not need staff support all of the time. For example, one person told us, "There is enough staff. At night there are two staff, they check on you every two hours. When I press the bell they always come quickly." Another person told us, "The mornings are ok but at night there is not enough staff. When I ring the bell it takes a long time (for staff to respond)." Another person had commented to a visiting professional that staff were not always accessible in the lounge for them to tell them they needed assistance. During our visit we saw staff had limited time to spend with people due to being focused on getting their care tasks completed. Staff did however respond to call bells in a timely manner when people used them. Staff told us they made regular checks of people to manage their care and ensure they were safe.

Staff confirmed that staffing levels enabled them to provide the support people needed but explained that some days were busier than others. One staff member told us, "Some mornings can be very busy and you can feel that you need an extra pair of hands. It is not a reflection of every day. We make sure we are aware of where everyone is and who is doing what. Some need two staff to assist and it will be decided who is going to help, so if two staff disappear, you know where they are."

We noted from looking at duty rotas, there had been times when no senior care staff member was on duty during the day. This was because there was only one senior care staff member employed. This meant there may not always be a senior staff member to support staff to ensure the home was managed safely and

effectively consistently. When we discussed this with the manager they told us, "Nearly every weekend I am on call and I don't live far so I don't have a problem with that." Staff told us that the manager always answered calls when they had contacted them out of hours. The provider said they aimed to have more senior care staff.

The manager explained that staffing levels had been set following a meeting with the provider where they had discussed people's needs and the number of staff required to meet their needs. When we visited, there were enough staff to support people's basic care needs. There were two care staff, a senior member of care staff and the manager on duty. The providers were also in the home to support the manager. At night there were two care staff on duty and staff who had completed shifts at night told us this was sufficient unless there was an emergency situation.

Staff told us they were not allowed to start work until the provider had carried out recruitment checks to ensure they were safe to work with people. We looked at two staff files and found checks had been undertaken before staff began work at the home. These included written references and satisfactory Disclosure and Barring Service (DBS) checks. The DBS carries out checks to see if a person has a criminal record which assists the employer to make a safe decision in appointing staff.

The provider had taken measures to minimise the impact of unexpected events such as fire risks. People had individual evacuation plans on their files so it was clear to staff and the emergency services how they would need to be supported in the event of an emergency. Information about each person's support needs was also kept an emergency folder at the evacuation point for emergency services as required.

Good

Is the service effective?

Our findings

People felt staff had the skills required to meet their needs. One person said, "They are very good; they know what they are doing alright. I couldn't say anything bad about them." Another commented, "They have regular training, I'm happy with their skills." A visitor felt staff had the skills required and told us, "They are all very knowledgeable, I find whoever you talk to, if they are not sure they go straight away to the person in charge."

Staff said when they were recruited they went through an induction process and commenced training to prepare them for their role. One staff member told us, "My induction included work courses 'online' and little tests to make sure I knew what I was doing such as moving and handling (people) and accidents." They went on to tell us they had also shadowed (worked alongside) other experienced staff so that they felt confident to carry out their role. They said if they were unsure of something there was always a staff member to help them. The provider stated in their Provider Information Return (PIR) that some staff had completed training based on the 'Care Certificate'. The manager confirmed during our visit this was the case. The Care Certificate helps new staff members to develop and demonstrate they have the key skills they need to provide quality care.

Staff said they completed training to support their development so they could meet people's care and welfare needs safely. This was confirmed in a training plan seen during our visit. This showed most staff were up-to-date with training the provider considered essential for them to carry out their role. The manager was aware of those staff who needed to complete updated training. One staff member said the manager and provider were supportive of providing any training they needed. They told us, "We asked if we could have learning disability and mental health training and they are organising this. They organised fresh moving and handling training so we were all up to date at the same time. [Provider] says if there is something we are not confident in, to let them know and they will organise training."

During our inspection we identified there were people in the home with dementia. Staff told us this was an area where they felt further training was needed. The PIR we received from the provider stated staff were to complete 'person centred care' and 'advanced dementia' training and this was to be sourced by the manager. The manager told us this was in the process of being organised to ensure staff were sufficiently trained to meet people's needs.

Our observations of staff demonstrated they put their learning into practice. For example, staff ensured people sat on pressure cushions to help prevent skin damage. We also saw staff wearing protective gloves and aprons to help prevent the spread of infection within the home.

The provider encouraged staff to gain nationally recognised qualifications in health and social care to further support their practice within the home. Records showed that most staff had gained National Vocational Qualifications (NVQ's) in care.

Staff told us they attended supervision meetings with the manager to discuss their role and training needs

to further develop their skills. One staff member told us, "She (manager) discusses possibilities for the future, areas for training, areas of strength and weaknesses." Staff also told us the manager carried out regular observations to make sure they carried out their role in accordance with the provider's policies and procedures.

The manager confirmed staff supervision meetings took place on a regular basis and any issues of concern identified during observations of staff were discussed at these meetings. This was so any further training they might need could be identified and arranged to ensure people were supported safely. For example, the manager told us, "I observed not perfect moving and handling (people) practice. I stopped them, it was a new member of staff. I told them how we are supposed to use correct moving and handling techniques and I arranged the training for all new staff as I thought it would be beneficial. Then I did another observation after a week and saw an improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The manager understood their responsibility to comply with the requirements of the MCA and the need to ensure staff worked in a person centred way, promoted independence and provided support in the least restrictive way.

Staff had received training in the MCA and had a basic understanding of the principles. One staff member told us, "MCA is allowing the ability for someone to make a decision assuming they have capacity." We noted that some people in the home could do things independently but there were others who needed a lot of staff support. Some people who were more independent told us staff asked them for their consent before they delivered care. One person commented, "They always knock first. I say come in. They ask my permission to do things." However we noticed this was not always the case for people. For example, one staff member put clothes protectors on people at mealtimes without asking first. One person told us, "They don't really ask, they just do things." We told the manager about this so it could be addressed.

People who were more independent told us they did not feel that any restrictions were placed on them which demonstrated staff supported these people in a way that helped to promote their independence. One person told us, "Not restricted at all. I go out most days on my own…I always see the doctor myself, I make my own appointment. I don't see a chiropodist, I do my own. I had an eye test a month ago, I went myself. I go in to the kitchen and get a drink when I want."

The MCA and Deprivations of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. The manager had ensured that some applications had been submitted where potential restrictions on people's liberty had been identified such as people being restricted from leaving the building due to a locked door.

The manager told us if a person was not able to make an important decision independently they would check if the person had someone who could support them to make a decision in their best interests such as a family member or advocate. However, it was not clear checks had been made to ensure people in this position had Lasting Power of Attorney (LPA) in regards to care decisions. LPA is the authorisation to allow

other people to make decisions on the behalf of the person. The manager told us they would check the necessary documents issued by the courts were available to confirm relatives and representatives could legally make decisions on the behalf of people.

People were satisfied with the meals provided. One person told us, "The food is alright, if you don't like it you tell them." We established alternative options were offered based on what food was available. Another person told us, "I eat all the food; you get a choice in the morning. I usually get what I order." People told us they had sufficient drinks and they could ask for one if they wanted more. We noted when the drinks trolley went around during the day people were not always asked what drink they wanted. People were provided with two choices of the main meal served at lunchtime and in addition there was a vegetarian option provided. One person told us they sometimes did not like the hot choice provided at teatime and it was not always possible for them to have an alternative hot choice. The cook told us the person could ask care staff on duty in the evening for something different. We noted that menus had been discussed at a 'resident' meeting and one person had requested more healthy options to be provided. This request had been actioned by providing salad.

Snacks such as biscuits were not routinely provided with drinks and we were told people could ask for them. We advised the manager that some people who were less independent may not feel comfortable to make requests or may not realise they could ask for snacks. In some cases there were instructions in care plans for people to have extra snacks to maintain their health and nutritional needs. An evening snack (supper) was provided to some people. A staff member told us, "They have supper at 8pm if they want toast or sandwiches. The night staff go around and ask and they make supper. Some will wake up at 2am for toast."

Most people sat down to eat together in the dining room. We saw sauces were applied by staff as opposed to people being able to do this themselves, even though they were able to do this. Some people had spouted beakers to help them drink independently. A staff member sat with two people at the dining table to help provide encouragement and support to eat.

The cook knew about those people on "soft" diets and prepared meals that were soft and easy to swallow to prevent the risk of them choking. The cook told us the menus had been prepared after speaking with people and the provider about what people wanted. Nutritional guidelines had not been used to influence the menus to ensure meals contained sufficient nutrition for people. We made the manager aware of this so they could ensure this was addressed.

Staff supported people to see the doctor when required and people said they were able to see a doctor when needed. One person told us, "The doctor is across the road, staff make the appointment." Another told us, "Staff make my doctor appointments it's across the road. The chiropodist does my feet. I have had an eye test and the dentist also comes."

A visitor told us how pleased they were that a doctor had been contacted straight away when they mentioned a health concern they had about their relative to a member of care staff. They told us when they next visited the home the staff member reported back to them what the doctor had said which they felt was "very good".

Good

Is the service caring?

Our findings

People felt staff did their best to care for them and were respectful. One person told us, "I'm quite happy with the staff, quite respectful they are." Another told us, "They are very respectful." A relative told us, "They are very respectful, I can't fault the girls at all."

During our last inspection we identified some people felt some staff were not caring in their approach. During this inspection, overall people were positive about their experiences of staff. We observed staff to be caring when interacting with people and they knew about people's needs and preferences so they could support them in ways they preferred. They knew where people liked to sit and about people's usual daily routines. There were occasions when staff were task focused at busy times of the day. However, staff provided assistance to people in a patient, calm and reassuring way. During late afternoon we saw a staff member spending time talking with a person who had limited sight and who clearly enjoyed this one-to-one time and responded positively to this.

Staff felt they were caring towards people and said they worked in a caring environment and worked as a team to support people's needs. Staff said sometimes there was a lot to do in terms of tasks they were required to complete and they told us this sometimes limited the amount of time they could spend with people.

People were supported to maintain relationships with those who were important to them and the manager told us they had 'open' visiting times. Relatives were welcomed into the home and we saw them visiting people during the day.

People who were more independent told us staff respected their wishes to spend their days how they wished. For example, one person told us, "I go to my room sometimes after lunch. Two or three others do the same."

People said staff were respectful and maintained their privacy and dignity. One person told us, "They are really good. When they shower me they say 'shall we wash your back, do you want me to leave the room?'."

Staff understood the importance of maintaining people's privacy and dignity and were mindful of this when providing personal care. One staff member told us, "When I go and get them up I make sure the door is closed and get them up and changed. When having a wash I make sure I ask them before I wash them. Ask them if they want to do their personal areas." The manager told us when they observed staff they checked to make sure people's privacy and dignity needs were met. They had completed two night "spot" checks since they had been in post and commented how well staff managed this. They said, "I was quite impressed."

Requires Improvement

Is the service responsive?

Our findings

During our last inspection people felt they were not involved in their care and staff were not always responsive to their needs. We found there had been some improvements in both of these areas but these were ongoing.

When Healthwatch visited in February 2016 they made a number of recommendations including introducing more activities for people and having a staff member responsible for a timetable of regular activities. The local authority commissioning team, who organised care and funding for some people at the home, had arranged for the manager to be supported by an occupational therapist (OT) to help staff in ensuring people received more person centred care. An occupational therapy student had been working in the home to help support this. The manager told us the support of the occupational therapy student had helped to improve people's experiences of living at the home. The student had been involved with staff in gathering more detailed information about people so they could support their interests, hobbies and wishes. A relative commented, "The student is excellent."

When the student placement ended in December 2016, the plan was for the provider to use the information gained to continue this work. At the time of our inspection this was still in the process of being addressed. Since the student had left, staff had limited time to spend with people to support their interests. The manager and provider were aware of the need to further improve social activities and increase the time allocated to be able to do this. Action had been taken to advertise for an activities co-ordinator to help improve activity provision but the provider had not yet been successful in sourcing a suitable person for this role.

People felt their basic care needs were met. People's needs were assessed before they came to live at Ashleigh House and information gained during this process was used to prepare care plans for each person. Care plans contained instructions for staff to follow to help ensure care was provided in accordance with people's preferences. There were plans for different aspects of people's care such as nutrition, mobility and personal care. There was also information about their life history such as names of family, friends, special occasions, and what their interests were. The manager told us that care plans were being reviewed to increase the amount of person centred information they contained. This was to help staff learn about things that were important to people and enable staff to provide care and social activities in accordance with people's preferences and needs.

Most people told us they had not been involved in reviewing their care plans and some people did not know what a care plan was. One person told us, "I have no information about a care plan, what is it? Not discussed my care." Another told us, "I think there's a care plan, not sure." People also told us they had not been involved in discussions and decisions about their care with staff. Comments included, "They don't discuss my care with me," and "We don't talk about my care." This suggested people did not feel involved in decisions about how their care was provided.

When we spoke with the manager about this they said people had been involved in their care plans and

explained why people may not have realised this. They commented, "We are trying to do it in a less formal way when reviewing care plans otherwise they 'seize up' and would not tell me as much as they would like to. Sometimes I would ask them for a chat and ask them how they are and what do they think about the care." The manager also told us people were involved in reviews carried out by social services when staff sat with people to discuss their care more formally.

During our visit we saw most people sat in one of the two lounges watching television. When lounges were full people chose to sit in the 'visitor's room' or dining room. We saw one person sitting with their relative in the dining room enjoying a board game. Another person was completing a jigsaw puzzle which they clearly enjoyed. One person told us, "We do coloring, painting, baking, bingo, exercises, and music. A singer came a couple of weeks ago." Some people felt their interests were not supported and commented that there were people who received more social stimulation than others. One person said, "I don't have any interests here, I just watch telly. We don't do anything, we don't do trips out." Another said, "I don't do anything, I just sit here. We don't do anything at all, I've never been out." One person commented they went out at Christmas and to parks in the Summer and a person who was more independent, told us they were supported by a staff member to go out occasionally.

People told us they knew what to do if they needed to raise a complaint. One person told us, "I'm quite happy to raise things with staff if needed." Relatives told us they had not made any complaints but they had confidence any concerns would be managed appropriately.

A complaints system was in place and the manager had recorded complaints received. There had been four complaints received during 2016 and these had been investigated and action taken in response to them. It was not clear from records that people were satisfied with the actions taken.
There was a complaints policy and procedure available but these contained inaccurate information and did not provide people with the names and contacts to approach should they wish to escalate a complaint. The complaints procedure was also not easily accessible to people as this was on display on the second floor of the home. Staff said if people came to them with a complaint they would refer them to the manager. One staff member said they would record it but was not familiar with the provider's complaints procedure because the one on display was not up to date. The provider and manager were made aware of this so they could take action to update it.

Requires Improvement

Is the service well-led?

Our findings

The provider had not fully met the requirement to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. We identified there had been recent accidents and incidents, including those of a safeguarding nature, that had occurred in the home that had not been reported to us as required. This meant we could not ensure appropriate action was taken in response to them to keep people safe.

This was a breach of Regulation 18 Notification of Other Incidents (CQC registration regulations 2009)

The provider did not demonstrate they fully understood the requirements of their registration and their responsibilities to provide quality care and support to people. They had returned their Provider Information Return when requested although information within this was not sufficiently detailed to fully support the inspection process. Systems and processes to monitor the quality and safety of care and manage risks were not sufficient to keep people safe.

Audit checks were not always effective in identifying areas for improvement. For example, the system to audit accident and incidents records was not effective in ensuring trends were identified and risks minimised to prevent them from happening again. We found issues of concern with medicine management that had not been identified during medicine checks

Some of the provider's policies and procedures were not available to staff or needed updating to ensure they had clear guidance about what was expected of them in their role and worked safely. For example, the 'Safeguarding' policy relating to management of abuse was not available. We found recent safeguarding incidents involving people had not been managed effectively to minimise risks.

Records were not always accurate to ensure people's needs were met consistently. For example, some care records did not show checks required by staff were carried out to keep people safe.
The provider's complaints policy was not up-to-date to ensure staff were clear about their responsibilities if approached.

We identified that sometimes there was no senior staff member to cover the home during the day in the absence of the manager. This meant there was a risk the home may not always be effectively managed to keep people safe.

We found processes and systems to monitor the service were not always effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance

People told us they were satisfied with the home and could not think of anything they wanted to improve with the exception of one person stating they would like to go out more. Comments included, "I can't think

of anything to improve" and "I would like to go out more, we never do anything." People had some links with the local community including those established with local places of worship and links with entertainers who visited the home six weekly.

Most people did not feel involved in decisions about the home that impacted on them. They could not recall being given opportunities to make suggestions or offer their views of the home through quality satisfaction surveys or 'resident' meetings. People commented, "Not had any meetings here," and "I don't know what you are talking about. We don't have meetings." There were two people who could recall a 'resident' meeting taking place. A staff member told us meetings had taken place with people in the past. They told us, "They (manager) asked if there are things people want to do, we encouraged people to tell us what they wanted to do. Some said they would like to go to town shopping, some like to go to Birmingham in Spring time." The staff member confirmed people had been taken shopping which showed people's views had been listened to. The manager told us they spoke with families regularly. They commented, "I keep in touch with most families by phone and post and we arrange meetings."

We saw quality satisfaction surveys had been sent to 15 people and they had received nine responses back. Surveys had also been sent to staff, professional visitors and relatives in November 2016 to ask for their views of the home. The outcome of these surveys had been analysed by the manager. Action points included looking at the menu and meals provided; ensuring people had a copy of the complaints procedure and reviewing social activities. Our inspection confirmed these areas needed improvement.

The outcome analysis of the surveys showed positive comments from visiting health professionals with three out of four scoring '10 out of 10' for professionalism of staff. All stated they were provided with the necessary information when they visited and said if care staff did not know the answer they were directed to a manager or senior staff member. Areas for action they commented on was record keeping, as this was not always accurate and more activities for people because "the residents love them".

Staff said the provider was in the home on a regular basis to complete checks of the building to ensure it was safe. They also spoke with staff and visitors to ensure the quality of care and services was sufficient. One staff member commented, "When they (providers) are here they are vigilant and focused on maintaining a clean and safe home. Any time we have asked for things, they have provided them such as new sheets and towels and are quick to provide it. They seem to care about us having all the resources to do our job." However, staff told us they disliked the use of CCTV which they felt was used to watch them. One commented, "I hate it and I think if it's for benefit of residents, it's in the wrong places." A discussion was held with the provider about the use of CCTV. The provider confirmed that they had sought legal advice to ensure this was used appropriately.

Staff meetings had taken place but it was not clear from the notes of meetings that staff were asked for their comments on issues relating to the running of the home or were able to offer their opinions about decisions to be made. One staff member told us they did have some involvement, they commented, "They tell everyone what's going on and everyone has chance to reply."

Staff told us they liked working at the home. One staff member told us, "I enjoy it, everyone gets on with everybody." Another staff member told us "Everyone here is so lovely to speak to, all the residents are lovely, it is a lovely place to work, homely." Staff told us they knew what was expected of them in regards to their role because this was made clear to them during their induction period. One staff member told us, "When I did my interview they told me what my role would be and what I would be doing in the home."

We received positive comments about the manager and provider and staff felt supported in their roles. One

staff member told us "I think [manager] is dedicated ….she is focused and really attentive for anything we go to her with. She is focused on us as much as the home, it's nice to have someone you can joke at and also say you have a problem."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission without delay, notifiable incidents that impacted on people's health and safety such as those resulting in injuries to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the health and safety of people were not managed consistently to keep people safe. This included risks to people when they had been involved in incidents and accidents in the home. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from risks associated with their health, safety and welfare because systems and processes to monitor the service and drive improvement were not always effective. Regulation 17 (1)