Ideal Carehomes (Kirklees) Limited

Ashworth Grange

Inspection report

Ashworth
Dewsbury
West Yorkshire
WF13 2SU

Tel: 01924869970
Website: www.idealcarehomes.co.uk

Date of inspection visit:
18 January 2016

Date of publication:
21 March 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Ashworth Grange took place on 18 January 2016 and was unannounced. The home had previously been inspected in July 2013 and found to be compliant with the requirements of the Health and Social Care Act 2008 and its associated regulations.

Ashworth Grange is a purpose built care home registered for 64 people, some of whom may be living with dementia. There were 60 people in the home on the day we inspected. The home is organised into four units, two of which specialise in caring for people with a diagnosis of dementia and are accessible only by a secure keypad. There is an integrated garden area on each side of the home with seating areas and shelter.

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.

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

People and relatives consistently told us there were not enough staff. We saw this throughout the day as we observed the length of time to answer call bells and also periods when communal areas were left unattended. This was also stated by staff who felt under pressure to deliver all their key tasks and were aware of people being left unmonitored.

We also found, due to staff swapping units every shift, that knowledge of people's situations was scant

despite there being a handover. This included very basic of information such as how many people staff were actually caring for. This was evidenced by one staff member counting the files in a cupboard.

Risk assessments were not completed properly and lacked detail such as when someone needed equipment to assist them to move. Staff's knowledge of the fire evacuation procedure was unclear for people nursed in bed and the home did not meet its own requirement for the number of fire marshalls which stipulated six staff.

Staffing levels did not vary according to need. The rota was set at nine staff per day and four at night. The registered manager told us that staffing levels were due to increase to one more per shift but this decision was to provide an extra set of hands and was not based on any analysis of people's needs.

There were high levels of unwitnessed falls and some of these had resulted in hospital attention. These had not been reported to the Care Quality Commission in line with regulations.

Most staff had received mandatory training but this was out of date, especially in regards to the safe handling of medicines. This included the registered manager who assessed others' competency but whose own training had expired in 2011. Staff did have supervision and appraisals but these were mostly generic.

The home had not requested any Deprivation of Liberty Authorisations as they were felt these had not been necessary as people were not trying to leave the building. The understanding of mental capacity was poor in terms of the assessments as these often contained conflicting information.

We did not see people offered much choice over their food and nutrition and found that people recognised at being at risk of weight loss were not being monitored effectively as records were not up to date or informative. Staff did not always adhere to people's identified needs in their care plans such as with pressure care or communication support.

Staff were kind and considerate, demonstrating patience with people who needed extra support. They endeavoured to respect people's privacy and promote their dignity as far as time allowed. We could not see much evidence of people being involved in their own care planning although staff told us how they supported people to make as many decisions for themselves as possible.

There was a lack of organised activities for people to engage with, especially in the specialist dementia care units.

We found only one complaint logged and this had been dealt with in a timely manner.

There was a mixed view as to the atmosphere in the home. Some people and relatives spoke very highly, others told us that staff were always busy and so this impacted on their response. Some staff found the registered manager accessible but others felt things did not change despite them raising concerns.

Despite a comprehensive audit programme, we found that much of the audits were tick lists rather than a source of seeking to change and improve the service.

We found breaches in regulations concerning staffing, safe care and treatment, consent, safeguarding service users, nutrition, person-centred care and good governance in addition to notifications.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People, their relatives and staff all told us they did not feel safe as there were not enough staff to provide support. Call bells were left unanswered for long periods of time and staff lacked knowledge of people's needs due to constantly swapping units.

Staff did not gain the information they needed from risk assessments and the home was not adhering to its own fire risk assessment in terms of staffing levels.

There was a high number of unseen falls and no effective management of these and medicine records did not always reflect a person's needs.

Is the service effective?

Inadequate

The service was not always effective.

Staff had not received up to date training, especially in regards to the safe handling of medicines and supervision was basic.

Staff and the registered manager did not understand the purpose of a capacity assessment and the home had not requested any Deprivation of Liberty authorisations.

Although people were supported to eat and drink, records of nutritional intake were not accurate and staff did not have an awareness of appropriate pressure care.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and considerate in their interaction with people, and respected people's privacy and dignity wherever possible.

There was little evidence the service was pro-active in gaining people's consent for receiving care in records but we did observe staff trying to encourage people to do as much for themselves as

possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was limited opportunity for people to join in activities, especially where they required support to do so due to lack of staff.

Although care records were completed the needs were not always a true reflection of an individual's situation and we did not always see them followed in practice.

The service had only received one complaint according to its records which had been addressed.

Is the service well-led?

Inadequate

The service was not well led.

People and staff had mixed views about the home as some people felt it was good but others found that lack of staff availability and that staff were not always listened to did not mean quality care for people.

Some staff felt the registered manager was approachable but others felt things did not change if they raised a concern.

Although the home had audit systems, these were not robust and did not identify key areas of concern which were evident on the day of inspection.

Ashworth Grange

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.

This inspection took place on 18 January 2016 and was unannounced. The inspection team consisted of three adult social care inspectors.

Before the inspection we had received information of concern from relatives and external organisations as to the level of support people with dementia were receiving. We also liaised with the local authority safeguarding and commissioning team. We had not asked the provider to complete a Provider Information Return (PIR) as the inspection was brought forward due to concerns about the service. 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 spoke with five people living in the home and six of their relatives. We spoke with eight staff including six carers, the deputy manager, and the registered manager. We also spent much of the day observing people in the specialist dementia provision.

We looked at five care records including risk assessments, mental capacity assessments and food and nutrition charts. We also looked at three staff personnel records including supervision and appraisal records, minutes of staff and resident meetings and audits including accidents, medicines and care plans.

Inadequate

Is the service safe?

Our findings

We asked people if they felt there were enough staff. One person said "I wish there was always somebody there. It's not fair, is it really?" Another said "Some days they have a lot of work on. Some days they are whizzing around." This was reflected in comments by two relatives who said "Sometimes we come and just can't find anybody. We know they're busy seeing to people but there ought to be someone in the lounge."

Staff also told us there were not enough staff. One staff member said "There's not enough staff, that's a fact. We're fighting a losing battle." Another staff member told us that leaving only one member of staff on a unit at night was 'unsafe practice' and that the deputy or registered manager would cover but only in an emergency. At 2.30pm we observed staff asking for support from their colleagues as they had not anything to eat since coming on shift that morning at 7.45am.

One member of staff told us that "extra staff had been brought in for today's inspection." This was domestic staff as there were two on duty and we were advised this was not usual practice. The same staff member told us "There are not enough staff as we can't get through our duties which include stripping and making beds once a week (they are changed more often if needed), checking mattresses on bed changes, filling and emptying the dishwasher, serving meals and making suppers. Someone may need 30 minutes if they need assistance with a bath or shower and need the hoist. When we are busy then people have to wait and this isn't right." A further staff member also said "If two staff are needed in someone's room there is no one left for other service users." They also confirmed the situation overnight where staff may be leaving one unit to help on another if someone needed pressure care or assistance. This meant that a unit could be left without any staff oversight.

Call bells were not responded to promptly due to lack of staff availability, and in one instance because staff said they had not heard it. The longest response time we noted was 40 minutes. We observed one carer going into a different room to assist someone despite the call bell for the room opposite having been ringing for 20 minutes at this point. When a staff member did enter the room where the alarm had been ringing, we overheard the carer address the person by name saying 'hello' and then turning off the alarm. However, they were not heard to ask if the person required anything. They then left and two staff later returned, over 50 minutes after the call bell initially started ringing, to assist the person. We looked in this person's care file and saw they had a diagnosis of dementia and other physical illnesses, and was also at high risk of falls.

The registered manager told us that staff rotated each shift between the separate areas of the home. This meant that there was no continuity in the provision of care for people, especially for those living with dementia which would exacerbate confusion and the building of relationships with staff. The senior carer was observed giving out medication during both the morning and afternoon. Each time they were doing this for the two first floor units it meant that for a considerable time people were left in the specialist dementia area with only one member of staff providing care.

At 10.20am there were no staff in the lounge as one was on their break but there were seven people in the lounge, all of whom were living with dementia. At 10.25am one member of staff returned for 2 minutes and

then left again and did not return until 10.40am. By this time two more people had entered the lounge. Between 10.50am and 11am there were no staff in the lounge. In this period we observed one person get a dishcloth from the sink and wipe another person on the head with it. This other person was asleep at the table so the dishcloth was put over their hands. The person with the dishcloth then walked away. They then rummaged in the bin and picked out a thrown away slice of toast which they put back. However, they then poked their fingers in an open pack of butter and wiped it on themselves. We alerted the staff member to this on their return.

We looked at the staffing rota and found that each day had a set ratio of nine staff every day and four at night. The numbers did not fluctuate according to the needs of people in the home despite the registered manager completing a detailed dependency tool which showed each person's needs. Medication was only administered by senior care staff who did not have protected time to do this but had to cover the medication in two units, thereby leaving one unit with only one member of staff at times. During the night if someone required two staff to assist this meant one unit was left without any staff. The tool indicated that 17 people needed support during the night, some due to their diagnosis of dementia and others due to their physical care needs and 14 people required the assistance of two staff with their personal care needs. This high level of dependency did not result in deployed or extra staff for pressure points during the day.

The registered manager told us that it had been agreed following a meeting the previous week that staffing was going to be increased to ten staff per day and five at night. However, this still not correspond with any analysis of people's needs and there did not appear to be any flexibility to increase staff per shift as may be deemed necessary. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing as people were left unattended for long periods of time due to lack of staff availability.

We asked two different members of staff how many people were in their section. One said "Erm, there's 16 to a floor, 2 empty rooms, so 14 I think. Yeah, 14 that's it." Another staff member in the same unit said "Erm, I've to think now. 13 I think." We later asked the deputy manager how many people were in this area of the home. They said '16 when full' but then went on to count the care plans in front of us to tell us it was actually 14. This lack of basic knowledge meant that in the event of an emergency staff would have been unable to inform the fire service of who was in their section. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment as staff were unaware of who was actually in the home.

Appropriate recruitment checks were in place, and staff were subject to Disclosure and Barring (DBS) checks before commencement of their role. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. The service used bank staff when staff called in sick and the registered manager confirmed sickness was not an issue.

Staff were able to explain what may constitute a safeguarding concern. One staff member told us "Abuse can be physical, emotional, verbal or institutional." They were aware of the need to report it to the registered manager and that it could be referred onto outside authorities to investigate.

One person told us they felt safe living at Ashworth Grange. When we asked staff if they felt people were safe, one staff member said "I think so. We have the codes on the doors and there are always staff around. We always make sure the doors are closed behind us so relatives don't mistakenly let people out." The registered manager advised us there had been no safeguarding incidents over the past year.

We discussed how the service assessed risk. One staff member said "I have been trained in distraction

techniques. Seniors and the deputies do the risk assessments but we do every day when we go into someone's room. People at risk of falls have sensors or a falls mat. Some have bed rails. Those with higher toilet seats have risk assessments and these have to be in place before they are used." Another member of staff initially told us there were not any risk assessments but then told us that falls risk assessments were in place and that these identified the need for equipment.

Knowledge was limited as to the purpose and significance of the risk assessment and we asked one staff member if the method of moving someone safely was recorded and they advised us it was not. Another staff member was asked who received training in completing a moving and handling risk assessment and they said "We don't have training" which was despite them telling us that all care co-ordinators change 'anything in the care plan'. We saw in one record 'staff to assist' and 'needs help with mobility'. However, the method or equipment were not specified. One person was on continual bed rest but there was no moving and handling plan in place despite requiring the use of a hoist to move them. This meant there was a risk of harm to the person or staff as there were no clear directions in place.

One staff member told us "There is a fire procedure to follow. We have fire training and go to an evacuation point." They advised us they would make a record of who was where and 'tell the person downstairs who was in charge.' However, when we asked staff about fire evacuation for people who were nursed in bed they were unaware of how they would respond. We looked at the fire risk assessment and saw it noted that there needed to be six fire marshalls on duty at all times. The home would be unable to fulfil this requirement as there were currently only four staff on duty at night. We pointed this out to the registered manager who seemed unaware of this requirement. This indicated the service was not operating safely as there were not enough staff to meet its own fire risk assessment.

We observed staff struggling to assist someone to the dining table to eat their breakfast. Initially they gave the person clear instructions such as "On three we are going to stand. You need to stay forward [name]. One, two, three, push" but the person was unable to stand. The person then decided they needed the toilet so one member of staff went to get a wheelchair, but on their return the person remained unable to stand. The staff members then assisted the person under their arm to stand. This is unsafe practice and could have injured the person involved. We reported the incident to the local safeguarding authority as we felt that staff had not received the right support in how to engage with someone with cognitive impairment to enable them to assist someone who was unable to follow verbal prompts.

We looked at accident records and found there were a high number recorded. Between 1-17 January there had been 35 falls, 24 of which stated said the person was unharmed. Descriptions focused on how the person was found rather than the looking at the cause of the fall. In one record for 17 January 2016 we read "During morning bed changes, [name] caught their head on the wall". No explanation was given or analysis as to how this could have been prevented.

In December 2015 a total of 43 falls had occurred. In the upstairs unit for people with dementia there had been 20 falls, five of which resulted in actual injury, including two which required hospital treatment. 12 of these falls had occurred between 8pm and 8am indicating people's need for support increased over this time, yet the staffing levels actually fell. This was reflected in the other specialist unit for people with dementia where 12 out of 13 falls were unwitnessed. The completed analysis was a tick box chart which identified the date and time of fall and summary totals. There was no further evidence of any specific scrutiny as to patterns or areas of special concern which meant the service was not considering how these falls could be reduced in number to reduce the risk of harm to people. This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notifications as the service is required to inform us of all serious injuries to a person living in the home.

We noted in one person's falls risk assessment that it said "[name] was at high risk. Due to poor mobility [name] has to be transferred with a stand aid. Due to poor mobility [name] has to be hoisted for transfers". This was in the same section and provided contradictory information for care staff as did the following section 'what I can do' which read "Can hold onto stand aid with clear instructions." This had been ticked as discontinued as of 20 November 2015 but then re-ticked on 9 January 2016. Again, there was no clear evidence as to the person's abilities. We saw recorded that this person had been referred to the GP on 12 January due to increased number of falls.

We asked the registered manager what measures had been put in place to reduce the risk of falls for this person. They told us as the person was very active it was difficult to implement many measures. They had a soft foam mattress and a gel heel pad in place when they were on bed rest which was supposed to happen during the afternoon. However, we noted this person in the lounge with their leg over the armchair and staff trying to encourage the person to get changed as they had spilt a drink over themselves. They refused to cooperate and when staff put their feet on the pressure cushion they immediately removed them. Staff did not appear to know how to approach them or gain their co-operation which meant they were not meeting this individual's needs as required.

In a different falls risk assessment we noted that despite someone being at a high risk, nothing was ticked in regards to risks of poor memory, pressure sores or other physical conditions all of which impacted significantly on this person's care needs. It was also noted that, on occasion, this person may need the use of a hoist but there was no moving and handling plan in place. This meant that staff were not given clear direction as to how to support one safely and this could have resulted in injury to themselves or the person. This is a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014 as the home was not doing everything it could to mitigate risks while providing care to someone.

We observed staff undertaking the medicine rounds. One staff member told us "We did the basic medicine training on our induction and then a long distance learning course. The registered manager checked my competency when I first started doing medication. I can't remember when I last had my competency checked but it will be when I have my refresher." They also said as there had not been any new staff there had not been any competency checks undertaken recently. A different member of staff said "I had my medicines training and was then supervised for two weeks. If anything new comes in the deputy or the manager show us." We asked if this was recorded but the staff member did not think so.

We saw the staff member giving detailed explanations to people about what they were doing and what the medicines were for. People were offered drinks to take tablets and were not rushed while taking their medicines. The staff member crouched down to one person and supported them while taking their medicine.

Each person had a Medicine Administration Record (MAR) which included their photograph, GP, allergy details, start date of any medicine and photographs of each tablet. Any changes to a person's medicines had been signed by two staff to ensure accuracy of details. The home used a biodose system which provided each person's medication on a four weekly cycle. Some medicines were not suitable for this system and these remained boxed. We saw these were dated once checked onto a person's MAR sheet. This was the same for creams which were dated once opened and body maps were in use so staff knew where to apply these. Time specific medicine was given by night staff to ensure people received it at the correct time although the time of administration was not recorded.

We saw the temperature of the room and refrigerators where medicines were stored were checked every morning prior to the start of the medicine round. We found stock levels to be correct. Staff were able to

explain what they would do in the event of an error including seeking medical advice and reporting to the safeguarding authority if needed. The staff member advised us "We check every day including all boxed medicines. This daily audit is signed by the deputy manager."

We were told that one person received their medicine covertly. The staff member said "I will try and give it in tablet form. If [name] won't take it, I will try and give it in a drink. If [name] still won't take it I will go away later and try again." We asked if agreement to this had been obtained from the GP or pharmacist. The staff member said "The GP said we could crush them or give with food." There were records of a visit by the Care Home Liaison Team and the outline of a decision taken to refer the person's non-compliance in relation to medication to the GP. It was recorded that the decision was in the person's best interests but we did not see evidence of a best interest discussion being held to discuss the decision or the method by which the home were to action this, and regular reviews as to whether this remained the best option. This was a further breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home was not ensuring medicines were administered safely in line with requirements for covert medication.

Where people had refused medication this was recorded on the MAR sheet and the reason why. The staff member said they would 'inform the GP if a person refused medication but they often just suggest keep trying and this is recorded on the care plan.'

One relative we spoke with said "There is an odour 'on and off'. Some days there is no smell at all and others it's very smelly indeed." We noted a strong odour in parts of the home which had been attempted to be masked by rather overpowering air fresheners. These were unpleasant and had the potential to cause problems for people with breathing difficulties due to their strength. We also saw that windows were open at the end of each corridor.

Inadequate

Is the service effective?

Our findings

We asked staff about their induction. One staff member told us "I had a week of training courses six days before I started. Then I did two days of shadowing and then I picked up the rest as I went along. We covered safeguarding, moving and handling, the Mental Capacity Act, safe handling of medication, first aid, health and safety, challenging behaviour and intervention and hand hygiene."

We found that staff had regular supervision sessions. One staff member told us "It's every few months. I've had few since I started. We discuss how things are going and receive feedback on how things are working." Most had five per year with the registered manager. However, these followed a prescriptive format and did not explore any issues in depth. Most began with a resume of a staff member's role but did not include discussion as to how they were performing in this or whether they had any issues. Furthermore, most repeated themselves with the same overall comments and feedback.

Appraisals contained a checklist by which each staff member was graded such as caring attitudes, professionalism or knowledge and a brief overall two sentence summary of their performance. For each record we looked we saw the key objectives were 'complete training as required'. However, it was clear this was not happening according to the training records we scrutinised and was therefore an invalid objective. Records were signed and dated by both employee and the registered manager.

One staff member said "Once a year training is refreshed. I completed my NVQ level 3 while here." We looked at staff training records and found there were significant gaps where training had expired. This was especially so in the safe handling of medication where 19 staff members' training had expired. This included the registered manager whose training had expired in 2011 and both staff members who were administering medication on the day of inspection. Other areas where there were shortfalls were infection control (16 staff) and health and safety (13 staff). We asked the registered manager about these shortfalls and also they were aware there was no clear timetable in place to address this. The registered manager said that most learning was now done on the computer and staff could access this in the office or reception area as required.

This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider was unable to demonstrate that staff had up to date knowledge, especially with regards to the safe handling of medicines and moving and handling practices.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with staff about their understanding of mental capacity. One staff member said "It depends on people's capacity to understand such as with medication or whatever you are discussing. I've known before people have gone through families and relatives, and best interests if the person hasn't capacity." We asked them how they supported people on a daily basis and the staff member told us "I'd explain to them what sort of day it is and which option I think would be better while still giving them choice to choose themselves." Another staff member said "While people can make a choice they are deemed to have capacity. It can fluctuate and some people are worse on some days. Sometimes they don't understand risk and in these situations we have a mental capacity assessment in the care profiles which is updated every month."

We looked at capacity assessments in people's care records and found them to be incorrectly completed despite staff having a basic understanding of how to assess capacity. On one person's care records it said the person had a diagnosis of dementia but no impairment of the mind, brain or memory as would be expected with such a diagnosis. The assessment continued to say the person was always able to retain information but in their monthly review it said this wasn't the case. In a different capacity assessment it also said the person had dementia and was unable to remember that their balance was poor and would try to mobilise independently, putting themselves at a high risk of falls. However, this was not reflected in the capacity assessment as again it indicated no impairment of memory function. In the attached restrictive practice assessment it stated the person was unable to understand, retain, weigh up or communicate their decisions in any form. This lack of clarity evidenced by inaccurately completed capacity assessments is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as it demonstrated the home did not understand the legislative framework in which it was required to operate and meant that staff did not have clear indicators to follow to support people in the home due to the incorrect information.

We were advised by the registered manager that no one currently had a DoLS authorisation in place. They shared with us a copy of a letter from the local authority showing how the local authority were processing DoLS applications. However, we saw that the home had not made any attempt prior to receipt of this to look at people's restrictions. People living in the specialist dementia sections of the home all had their liberty restricted as there were keypads on the doors. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safeguarding service users from abuse and improper treatment as people were being deprived of their liberty without an appropriate authorisation in place.

People said to us "We get well fed here" and "I used to be a cook in my job and the food's good I can tell you." Another person told us "I had a nice lunch." One person said "I don't like the juice, it's like water." Another said "The food is much the same. Sometimes you feel it would be nice to have something different." We spoke with relatives about meals and one relative told us "I have been asked to leave at lunchtime as staff said this time is 'protected'. I'm not sure what this means."

We observed the lunchtime experience for people in three of the four sections of the home. We saw that staff wore appropriate personal protective clothing and tables were laid with tablecloths, condiments, cutlery, napkins and glasses. However, not everyone was asked their choice of beverage and meals were pre-plated from the hostess trolley. Staff in some areas had a list of what people had requested, however, we only saw people being given sausage, egg, chips and beans initially. People did not have the option of choosing portion size.

People were supported and encouraged to eat as much as they could during lunchtime. We saw one person did not eat their sausage and egg and so were presented with a salmon fishcake. One person did not want a cooked meal and so a staff member said "They might eat ham and beetroot on white." At no point was the person addressed directly despite them being nearby. The sandwich was brought promptly. During the day we noted that some people were offered a choice of drinks but this wasn't consistent across the home. There was a jug of juice and packets of crisps on a side cupboard but we did not see anyone have these.

We asked staff where it was recorded how much people ate and drank. One staff member told us "In the care plans." Another staff member said "It is recorded on a food and fluid chart if the person is having their weight monitored." However, when we asked them if this applied to anyone at the time of inspection they were unsure. We looked at the food charts for one person and found the information to be sketchy. It recorded amounts such as 'half' or 'x 1' but there was no reference point as to what this meant. Under biscuit/snack it was noted 'juice'. There was no obvious analysis of the information.

In the specialist dementia unit one staff member said "We only record if they have had had a good or poor diet. We ask people if they have had a drink." When we pointed out the reliability of this information, the staff member said "I will offer them another one." We asked them if a person can not remember having a drink where is this recorded, and we were told 'it isn't.' We saw incomplete food and fluid charts for six people in the upstairs unit. They had not been completed by 11am or 2pm.

In one person's care record it was noted that they had been weighed seven times since mid- November and during this period had lost 7.4kg. The care plan mentioned GP involvement and a slight increase in weight. However, this did not reflect the records we saw. The only action to be taken was 'to encourage food' and yet this person's nutritional intake was not being recorded. In a different record we saw someone had lost 2kg in a month and the only action taken was to 'assist with eating and drinking'. This meant the home was not appropriately monitoring people's nutritional intake. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 meeting nutritional and hydration needs as people were not being monitored effectively and therefore at risk of significant weight loss.

We noted that people had signs on their doors. However, these appeared to be based on their gender as females had flowers and men had cars rather than people's own preferences and identity. Some people had their photograph on their door. We looked in people's rooms and found that many were untidy with clothes and clean bedlinen thrown across chairs. Some beds were not made properly, especially where the base sheet was not fitted. In one room this was just hanging down over the mattress. In another room there was a vase of dead flowers which had obviously been there some time and in the en-suite the lid had been left off some emollient cream.

We asked staff about who needed support with pressure care. One staff member told us "Some people have pressure mattresses, cushions and heel pads. Turns are recorded for people." Another staff member also told us positional charts would be in place if they became concerned about someone's skin integrity. We looked at one such chart and found it incomplete in terms of when pressure care was given and the other detail was minimal.

We saw in the one of the specialist dementia units that no one was on a pressure cushion despite us reading in care records that at least one person did require one. We asked one staff member about the pressure relief for this person who was in a wheelchair and were told "I'm not aware of any pressure cushion in place. I think we have to stand [name] and they're re-positioned when they're in bed but I don't know about a cushion." This person was in their wheelchair from 9.15am until 2pm and at no time did they have a pressure cushion. They were then seated in a comfortable armchair at 2pm. This meant that they had not received

the appropriate care and support pertinent to their needs and had been placed at risk of developing pressure sores. This is a further breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as staff did not demonstrate their competency in caring for this person safely.

We spoke with a visiting community staff nurse who visited the home regularly. They told us they had the access code to the building as staff were not always available to let them in. However, they did say "staff are usually floating about." We asked them how information was shared between them and the home. They told us "We record in our own notes which are kept here, but not in the person's file." They said records of their visits are in the person's care plan which we saw later. We were told "the receptionist knows all the details." We did not feel this was an appropriate source of information. They told us they did not have any concerns and liked visiting the home as 'it was organised well'. We saw evidence that the staff called external professionals as required and in a timely manner.

We also saw the GP visit the home and we asked staff why they were there. One staff member replied "I don't know. I don't if the person is unwell. No one has said anything to me. It may be routine." We later asked the deputy manager and they advised us it was because the person had not been eating or drinking. This information had not been shared with the staff working on the unit that shift despite every staff member telling us there were three handovers during the day, at morning, mid-afternoon and evening.

Good

Is the service caring?

Our findings

We spoke with one person living in the home who said "Staff are very good and kind. Everyone gets on with each other. " Another told us "They're so good to me." We also spoke with relatives, one of whom told us "Staff know my relation's needs. They have a keyworker. Staff are always polite and always very approachable." However, they were also aware that the units were left with only one member of staff when the senior carer was doing the medicines round. Another relative visiting the home told us "Staff are always very kind and caring." A further relative visiting the home said "My relation is always clean, well dressed and smart."

We observed staff to be caring and attentive to people during the day when dealing with individuals. Staff addressed people by name and ensured they were happy with the support they had been given whether this was the provision of food or assistance with re-positioning. Staff were noted to be encouraging in all units during lunchtime, especially towards those with a poor appetite. We also saw when medicine was administered that the interaction was kind and caring.

One person began to cry and a staff member went over to them and was very kind and caring. The staff member responded quickly to provide the person with reassurance and offered comforting words. A moment later we saw that someone had become disorientated on the corridor and a member of staff went to them and guided them into the lounge area.

Staff acknowledged people when they spoke. We saw one person asked for a pudding and the staff member replied very patiently "I'll just finish serving and get you some pudding." This was duly provided.

One staff member went to assist someone to get up and they knocked on the person's door before entering, asking them if it was OK to enter. We heard them chatting away to the person informing them of the weather and asking them if they were ready to get up. When the person came out of their room they were assisted by the staff member to go into the lounge and encouraged to use their zimmer frame appropriately. It was very evident that there was good rapport between the person living in the home and the staff member by their interactions.

Another member of staff went to assist someone else who was just waking up. Again, they showed consideration and respect to the person, saying to them "I bet you're thirsty, you sound dry. I'll get you a nice drink. What would you like?" The whole conversation was delivered in a caring and warm manner.

It was recorded in one staff member's notes that they "[name] is pleasant and gets on well with everyone." In another file it said "[name] promotes people's rights and respects choices. They are liked by staff and residents." However, there was no further evidence apart from the registered manager's opinion.

We asked staff to tell us about particular people they were keyworker for. One staff member told us about someone who became anxious. "When they shout out I go and sit and talk with them, and they will talk with me." They were also able to talk about someone who required a specialised hearing device. Another staff

member informed us about someone who used picture cards to indicate their decisions as verbal communication was difficult for them.

Another staff member told us about one person who had lost their relative at a young age and liked to carry this person's photograph with them. They said "I make sure their pictures are there for them and safe as they tend to walk around with them on their trolley."

We discussed how people were supported in making choices in the home. One staff member said "Every day they have choice of what to eat from the menu, what they want to wear, where they want to sit and whether they wish to stay in their room." They continued "I will ask people to wash their hands, face, brush their teeth, make their own breakfast and cup of tea if they can. This is all to promote their independence."

We asked staff to explain how they respected someone's privacy. One staff member said "I always keep the door closed during care. I always knock and make sure they are covered up with a towel. We all do this." Staff also told us how they respected someone's preferences such as ensuring someone always had a female carer as this was their wish.

Requires Improvement

Is the service responsive?

Our findings

One relative we spoke with was happy with the quality of care their relation received apart from "Some elements of personal care are not done, for example they have dirty fingernails." We had noted this earlier in the day. Another relative told us about the activities, "My relation likes the singers who come every month. There have also been visits from the owl sanctuary and we've seen people bake and make things. The activities co-ordinator does table tennis and 'Oompf' which is like a music and exercise class combined." 'Oompf' is a national initiative promoting inclusive exercise and activity for older people, especially people living with dementia.

We spent a considerable part of our day in the lounges for people living with dementia. We observed that there was very little activity going on throughout the day for people to engage in. This was partly due to lack of available staff. In the upstairs lounge first thing we found nine people in there. Seated at one table there were three people, two of whom had their heads on the table asleep, and in the nearby lounge area in the armchairs were a further three people asleep. Music was playing and the TV was on but there was no sound. There was little interaction between people.

This was reflected around teatime where only one staff member was present for a period of 20 minutes. During this time this staff member was assisting people with their tea, making drinks and washing up. They also had to leave the lounge at intervals as someone outside the lounge was becoming distressed. While they were out of the room one person living in the home looked through all the kitchen cupboards and started to wash up and remove table cloths from tables, putting them under the armchairs in the lounge area. This lack of observational support from staff could have led to a more serious incident or harm to the individual or others.

We found a 'floor management file' which comprised the staff handover notes and an activity planner. The activity planned for the morning of the inspection was 'music'. This was provided as the CD player was on. One staff member told us that activities were arranged and the 'coffee shop' was very popular. This was a lounge arranged in the style of a café. We did see this in use by some people during the day. They also said there were regular movie afternoons, jigsaws, bowling and regular entertainers who came in to sing. The home also arranged themed food afternoons, with Italian being planned for the next session.

We looked at people's care records and found them to have had regular reviews. We saw in one person's file it said "To wear my glasses and my hearing aids." However, we saw this person did not have either on despite the care plan having been reviewed on a monthly basis.

Each person had a care profile with their admission details, life history and key contact information. There were care needs assessment for areas such as health and wellbeing, pain, communication and respect, hygiene and personal care and mobility. The care needs were written to reflect individual preferences noting factors such as one person's preference to get up late. However, we noted this person remained in bed all day so the records were not an accurate reflection of their current level of need.

We saw that daily notes were recorded up to the previous day. They were mostly task-focused describing the care provided such as personal hygiene and a check of skin integrity. The records contained a consent form for the sharing of information which, if signed, had been signed by relatives in most cases. We did not see any evidence of people themselves having been involved in discussing their care needs.

These examples demonstrate a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 person-centred care as people were not always receiving care in line with their care plans.

One staff member we spoke with said "People will tell us sometimes what's important to them, or their relatives who put up photos in their rooms. They talk about them and carry them around in the lounge." The same staff member said "Sometimes we have church services here and we tell people what time it will be so they can go if they want. We ask people living with dementia and will go with them although they might not stay for the whole service. We still give them the choice." This showed that this staff member was aware of the importance of supporting people living with dementia to make their own choices and follow their preferences, by being flexible and supportive.

We saw evidence of compliments including "Ashworth Grange is a lovely, pleasant and caring place. We were always made to feel welcome and nothing was too much trouble."

We asked staff how they handled complaints. One staff member said "I've never had any but we would follow the complaints procedure." Another staff member said it would depend on the issue. If, for example, it was about missing clothes they would deal with this themselves but would refer to the registered manager if the complaint was more serious.

The registered manager told us there had only been one complaint from the previous year which had been dealt with by the area office due to the issues regarding finance. We were unable to see if there had been a successful resolution.

Inadequate

Is the service well-led?

Our findings

One person living in the home said "It's a nice place, isn't it?" and another was keen to say "I do like living here. However, sometimes when they are busy they make an excuse." A further person said "I like living here. I can't find fault with it." One relative told us "I'm always made to feel welcome and staff are very friendly." Another relative said "I know the manager and can approach them about anything. I feel I always get a suitable response. I've no complaints."

One staff member said "I enjoy working here. I like the atmosphere with the staff and the residents. There is always a deputy manager around." Another staff member said "Everyone is friendly and people work together. I've never worked anywhere where people get on as well as they do here." A further staff member said "I love working here. Everyone puts people first. We all think the same."

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

We asked staff what they felt the home's values were. One staff member said "For it to be a nice place to live. People can have help when they need it but remain independent. To be able to socialise with other people." A different staff member said "Independence, choice and individuality. It's their home." This showed that staff were aware Ashworth Grange was people's home and they were there to assist in promoting their wellbeing.

We saw that the home asked people for their views and meetings were held with people living in the home. A range of issues had been discussed over the past year including the premises, food, outings and activities. There was no indication how many people had attended or contributed to these but it was evident from the meeting minutes that people had been listened to. For example, a shop had been created following people's request and people had suggested places to visit including a local tea room. People from the home had visited there the previous week. The findings of these meetings were displayed on noticeboards in each unit.

We asked staff how they found out information and shared their views. One staff member said "I haven't made any suggestions for improvement but I do think the management listen to you. They are approachable and supportive. Leadership is good. They see us nearly every day and talk to us, making sure you are OK and that things are OK." A different staff member said "The registered manager is very approachable, no matter what the problem is."

However, other staff members had a different view. One told us "We just get told things and there's no opportunity to say anything." Another said "The managers are not supportive and do not listen. We are told there can be no more staff because 'the government says so'". A different member of staff told us "People

like to get ready for bed from 6pm and there's no time to see to everyone who needs it. When we raise this with managers we are told 'there is no money for extra staff'." A further staff member said "If I had a magic wand, I would double the staff levels so no one would have to wait."

The registered manager held bi-monthly staff meetings. Attendees were listed but apologies were not. There was no indication how information from these was shared apart from the occasional reference in people's supervision notes. The registered manager discussed key points such as ensuring care plans were evaluated monthly and relevant and that staff were to offer alternative activities if people did not want to participate in the planned ones. In the latest meeting minutes for night staff we noted they had requested the option to wear night clothes in an attempt to support people with dementia as they had seen recent coverage on the television about best practice. The registered manager had agreed to this but advised us staff had yet to do it. The agenda was detailed but not all areas were discussed as records in the minutes were brief. Topics included communication, activities, employee of the month and falls reporting which were missed learning opportunities for staff. There was very little evidence that staff contributed to any discussions.

We asked staff how they knew they were delivering a quality service. One member of staff said "We always try and make the resident happy and do as we are trained to do. We provide the level of care you are supposed to do." Another staff member said how they had learnt from a previous safeguarding incident which had led to further training for staff so they all knew what to look for. The registered manager told us there was an employee of the month scheme but staff did not mention this to us.

There was a lack of management oversight in regards to practice for key areas of care such as falls and moving and handling. Risk assessments including moving and handling were poor as they did not convey enough detail about the method of transfer. The home had comprehensive list of audits, however we found most of these were tick lists and did not contain any detail of changes. Most did not indicate areas of improvement and there was a lack of subsequent actions. There was a monthly analysis of accidents, activities, complaints, fire safety and safeguarding for example. However, some of these had been completed by the time of our inspection which did not suggest effective auditing as we were only midway through January.

The pressure sore audit contained details of a grade 2 pressure sore and the treatment plan in place such as pressure relief through positional changes and referral to the district nurse service. However, we did not see this happening in practice as we had observed this person through the day. The activities audit referred to discussion about these at the residents' meeting which we saw in the notes. It indicated that people could contribute by buttering bread or peeling potatoes, but we did not see any evidence of this during the inspection. The dementia friendly audit looked at the environment saying that lighting was bright so people could see in the corridors easily. We mentioned to staff and the registered manager how dark it actually was down some corridors, especially for the staff member doing the medication round.

We saw the complaints audit for January had been completed on 12 January 2016 and showed there were no complaints for that month. The completion date showed this was not accurate as the month had not ended at this point. This meant that the audits were not an accurate reflection of the events in the home. Falls resulting in serious injury had not been reported to the Care Quality Commission as required under Regulation 18 Care Quality Commission (Registration) Regulations 2009.

These examples are a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems were not able to monitor and improve the quality and safety of the services provided as they did not reflect the actual experiences of people. The systems were superficial as they did not identify areas of weak practice, especially around staffing levels and people's safety.

We saw that all health and safety checks were completed as required including gas and electrical appliance testing, lifts and equipment such as the hoists.

We asked the registered manager what they felt the key risks to the service were and they said they did not feel there were any at the present time, and 'things would improve once we have more staff.' They felt their key achievements had been in 'having a happy and safe home, liked by residents and staff'. The registered manager said "I am organised so I know what's going on." We asked how they knew this and they told us "I visit the units regularly and observe what staff are doing. I will tell them there and then if they are not doing something right." We did not see that staff were always acting in the appropriate manner such as when trying to support someone with their mobility as they showed a lack of awareness with regards to understanding communication and basic moving and handling techniques. There was no written records of observations having been undertaken and staff supervision notes did not reflect if poor practice had been identified and remedial steps taken. The registered manager spent much of their time in the office in the reception area during the day while we were there.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service was not informing us of all serious injuries to people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving care in line with their care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments lacked clarity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not being monitored effectively and therefore at risk of significant weight loss.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff were unaware of who was actually in the home.

The enforcement action we took:

Warning notice to be complied with by March 24 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service had not applied for any DoLS authorisations despite people not being free to leave.

The enforcement action we took:

Warning notice to be compied with by 24 March 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not able to monitor and improve the quality and safety of the services provided as they did not reflect the actual experiences of people.

The enforcement action we took:

Warning notice to be complied with by 24 March 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were left unattended for long periods of time due to lack of staff availability.

The enforcement action we took:

Warning notice to be complied with by 8 March 2016.