Care Quality Commission

Embrace (England) Limited

Ashwood Park

Inspection report

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Ratings

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

Overall summary

This inspection took place on 23, 24 March 2015 and 2 April 2015 and was unannounced. This meant the provider did not know we were inspecting the home at that time.

We last inspected Ashwood Park on 2 July 2013 and found it met our regulatory requirements.

Ashwood Park is registered with the Care Quality Commission to provide care for up to 65 elderly people. The home provides a mixture of residential care both with and without nursing, and provides care to people with dementia type conditions. At the time of our inspection there were 60 people living in the home. The provider had recently altered the ground floor accommodation to separate people with dementia care needs from those with nursing care needs.

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

Summary of findings

and associated Regulations about how the service is run. During our inspection we found the previous registered manager had left the service and a new manager had been appointed. On the first day of our inspection the new manager had been in post six days. They expressed their intention to apply to become the registered manager.

We found staffing levels at the home needed to be reviewed in the light of our findings during the inspection. Relatives and staff told us the levels were too low to meet people's needs in the home.

We found there were gaps and errors in the records for people's medicines.

We saw the home had in place personal emergency evacuation plans displayed close to the main entrance and accessible to emergency rescue services.

We found the home in parts required further cleaning to reduce the risk of the spread of infection.

Since our last visit the home had been reconfigured and people who had dementia type illnesses were now restricted in their ability to walk continuously around the unit. As a consequence we observed staff supporting people to turn around at the dividing doors which had been put in place.

The provider worked within the Mental Capacity Act 2005. We saw that all people living in Ashwood Park had undergone a consent to support' and Mental Capacity Act assessments to identify their capacity to consent to their care. We also saw Deprivation of Liberty Safeguards were in place. This meant applications had been submitted to the local authority to deprive people of their liberty and keep them safe.

We observed staff speak to people in kind and reassuring ways. However we saw over a lunchtime period those who could not verbally communicate were not engaged by staff in any interaction.

People told us they felt their dignity and privacy were respected by staff.

We saw a notice board on which was displayed information about the activities for that week. During our inspection we found none of the activities on the board had taken place. We found further work was required to provide a stimulating environment for people who used the service.

We found the provider had audits in place to measure and monitor the quality of the service However we found not all of the audits addressed the deficits we found in the service.

We saw the provider had in place a complaints policy and the manager had investigated complaints and provided a response to the complainant.

When we spoke to the manager about the deficits we found during our inspection we observed them talking with staff, questioning practice and exploring solutions to the problems. We found the manager was willing to start to address service improvements.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The home had in place personal emergency evacuation plans located closed to the main entrance and these were accessible to rescue services.

People who lived in the home, their relatives and staff told us staffing levels were insufficient to meet people's needs. Our observations supported this.

We found there were errors and gaps in the recording of people's medicines. Staff who gave people their medicines could not be identified from a signature list.

Is the service effective?

Requires improvement

The service was not always effective.

People told us they enjoyed the food in the home. We saw people were weighed at regular intervals and action taken if people were losing weight.

Recent changes to the building did not support people with dementia needs.

We saw that all people living in Ashwood Park had undergone a 'consent to support' and Mental Capacity Act (2005) assessment to identify their capacity to consent to their care.

Is the service caring?

Good

The service was not always caring.

We spent time observing people and staff and found that staff spoke with people in a kind and reassuring way and that when people were confused, staff used appropriate means of communication to help them to relax.

We used a SOFI to observe a lunch time period and found staff spoke with people who could verbally communicate with them. However, we found people who could not verbally communicate did not receive any staff interaction.

People told us staff respected their dignity and privacy. We saw staff closed people's doors when they were delivering personal care.

Is the service responsive?

Requires improvement

The service was not always responsive

We found the activities set out on the information board did not take place. People did not have a regular programme of activities in place which they were either familiar with, wanted or provided a stimulating environment.

We found people had in place care plans and risk assessments which detailed their needs. People's needs were assessed before they lived in Ashwood Park.

Summary of findings

Although not all relatives we spoke with were confident the provider would respond to complaints we saw the provider had in place a complaints policy and there was written evidence to indicate complaints had been recorded, investigated and a response provided to the complainant.

Is the service well-led?

Requires improvement 

The service was well led.

We found the provider had in a place a number of monthly audits which checked on the quality of the service provision. These included the monitoring of the kitchen and accidents and incidents

When we pointed out deficits in the home to the manager we observed them undertaking the discussions with the appropriate staff, questioning practice and exploring solutions to the problems. We found the manager was willing to start to address service improvements.

We saw the regional manager visited the home on a monthly basis and checked on the quality of service provision. We saw the regional manager then produced an action plan and on their next visit they checked to see if improvements had been made. However we found the deficits in the service had not been picked up by the manager.

Ashwood Park

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 23, 24 March 2015 and 2 April 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors 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. The expert by experience on this inspection had experience in caring for older people.

Before the inspection we reviewed information we had on the provider including notifications, safeguarding information and whistleblowing information. We also contacted professionals involved in caring for people who used the service, including; Healthwatch, commissioners of service and Local Authority safeguarding staff. No concerns were raised by any of these professionals.

During our inspection we looked at people's care records. We spoke with eight people who used the service and four relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with ten staff including the manager, nurses, care staff, and support and catering staff. We also carried out observations and spoke who four professionals who visited the service.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection we spoke with staff and people about what was good about the service and we spoke with the new manager about improvements they intended to make.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe in the home. One person said "I am safe and happy here. If I was not pleased with anything, then I would tell them." We also spoke with relatives who said they felt their family member was quite safe within the home. One relative said, "Yes, I believe my mother is safe in here. If I thought she was not, then I would have her go elsewhere."

We saw in the entrance to the home a file which was accessible to emergency staff containing personal evacuation plans. This meant emergency services had ease of access to information about people when they might need to be rescued.

We talked with people about the staffing levels. One person said, "Yes more staff would be very nice. I am fortunate and get family coming in but there are others who don't have a lot of family."

We observed in one unit there was at times not enough staff to safely care for people. We saw staff showed signs of stress and agitation when they needed support from colleagues who were too busy to help. For example, we saw in the lounge one person had asked for a drink for some time and two other residents needed help to move. There was only one member of care staff available; they could not find any colleagues to help. We found a relative trying to get help and saw them standing in the corridor shaking their head. They said, "This happens all the time. They're lovely people but there just aren't enough of them, the company works them to the bone."

A staff member told us, "Staffing levels are dangerous. There are simply not enough staff. The medicine rounds take hours and people get their medicine late because we don't have enough nurses. On the night shift, things are even worse. One nurse for the whole building is dangerous."

We looked at staff recorded hours for payroll purposes. We undertook an analysis of care staff levels on four consecutive weekends between two and four care staff were recorded as working a nightshift. We could not be assured of a sufficient and regular level of staff to care for people at night.

During our inspection we learned an agency nurse had phoned in sick, one nurse in charge went home for a sleep and was to return to cover the nightshift as the manager could not source another agency nurse. This left one nurse available to cover three units. We found there was not an effective contingency plan for staff sickness.

We recommend the provider reviews the level of staffing deployed over the 24 hour period.

We looked at the Medication Administration Records (MAR) for 20 people on the dementia and general nursing units. We found there were errors and gaps in the recording of medication. For example we found medicines that should have been given at a lunch time period was still in its packaging and there were no records on the MAR to indicate the reason for this. We found there were further gaps in the administration of people's medicine and application of prescribed creams. We found that one person had gone without their prescribed medicine for three days. There was no explanation for this in the MARs or evidence of consultation with a medical professional. One staff member said, "Boots know that we are out of stock of these meds but they don't have any in stock so the person hasn't had any." We found there was no evidence that a medical professional had been consulted to find alternative medicine for the person. We asked staff about the gaps in the MAR charts and they were unable to provide us with an explanation, they attributed the errors to stress and not having enough staff on duty to cover people's care needs.

The home had a clear protocol for staff to use 'as needed' medicine (PRN). The records for administering this medicine were kept in the MAR charts and we found records were inconsistent. For example we found the signature boxes for these medicines were blank but staff could not tell us if this meant that they had been refused or that they were not needed.

The MAR records had a signature sheet at the front, which provided a sample of staff signatures. This was intended so that the person signing off each dose of a person's medicine could be traced. In most cases the signatures on the daily MAR records could not be traced using this because the signatures did not match any on the sample list. Neither a staff member nor the manager recognised the signatures in the MAR records that were sampled on the front page. This meant that we could not find out who had been responsible for medication on certain days.

Requires improvement

Is the service safe?

We found the registered person had not protected people against the risk of the unsafe administration of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a sign on two doors from the corridor leading to the garden, which said, 'Please ensure residents have access to the garden. Doors are not to be locked especially between the hours of 9am-4pm'. We found both doors to the garden were locked. We found a door from a lounge with a full length blind to the garden was open. We needed to push the blind aside to avoid tripping over the linked beaded chains in order to reach the garden. This meant people going outside were put a risk of tripping. We saw a wooden seat was across the pathway, people could not walk past the seat to gain access to the garden. We saw people had one access route to the garden which put them at risk and did not allow then to walk around.

We looked at the risk assessments in place and found the provider had identified where there was a risk to people for example one person's risk assessment addressed their low weight and provided details on how to increase the person's weight. However we found some of the information in the risk assessments contradictory. For example one person was diagnosed with a type of dementia and it was recorded there were no perceived risks, but later in the care plans it stated the person could not use their call bell and had to be checked every two hours. This meant whilst risks had been assessed there was a lack of consistency in determining what the risks were.

During our inspection we noted some areas of the home were dirty. Relatives told us they had found the home in a dirty condition. In one of the communal lounges on the dementia unit we noticed significant levels of dirt and dust around the corners of the room and underneath tables and chairs. One of the sofas in the lounge was heavily stained and when someone sat on it, a cloud of dust appeared. We observed the cleaning of the lounge. Only the central area of the floor was mopped; the dirty and stained areas by the walls and underneath the seats were not cleaned. The mop was dirty and there was an unpleasant odour to the dirty water in the bucket.

We looked in the bathrooms and shower rooms and found these to be dirty and cluttered. For example in one shower room we saw the toilet was dirty and there was a hoist in the shower room which impeded people's movement putting them at risk of trips and falls. We found one bathroom locked and asked a staff member for a reason. They told us a person gets in there and runs a bath. The bath contained a duvet. Also in the same room we saw a hoist, weighing scales and a toilet frame. This meant people did not have a bathroom available to them.

We heard a staff member giving a relative the access code to the relative's kitchen. We looked in the kitchen and found the cupboards were dirty. We saw used and stained medicine pots on the draining board and found a person's prescribed food supplements in the room. During our inspection this was converted to a clinical area, however the door code had not been changed. This meant relatives were able to access a room into which people's medicines had been transferred.

We found the upstairs unit has no outside phone line. We observed a nurse using their own mobile phone and spoke to the manager about this. We asked the nurse to explain to the manager they were unable to get an outside line on the intermediate care unit and had to leave the unit to use a phone. The manager apologised and offered to top up the nurse's phone in recompense.

We found the registered person had not protected people against the risk of the unsafe and unclean premises. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at three staff recruitment files to see if the provider had ensured staff were safe to work with vulnerable people, and had the skills and abilities required to carry out their role. We saw the provider carried out a Disclosure and Barring check (DBS). A DBS check requires prospective staff members to submit evidence of their identity before a check is carried out; the check tells providers if there are any offences recorded against that person. We saw staff had completed application forms detailing their previous experience and the provider had sought two references for each staff member. We found staff had been safely recruited to carry out their roles.

Requires improvement

Is the service effective?

Our findings

We spoke with people about their meals. One person told us, "I like the food, there is always a choice and it is well cooked – just as my mam used to do." Another person said, "I always eat in my room, I prefer it and it is not a problem to the staff. There is always a choice." The food is good and the staff and cook are lovely." A family member told us, "We are asked not to visit during meal times. I can see the reasoning behind that. My relative enjoys her meals; otherwise she would not eat them. She has put some weight on, so everything must be right for her."

We looked at the food and fluid intake charts for four people who had a risk of malnutrition. Staff had maintained a record of peoples' food and fluid intake. However we found the totals of food and fluid intake charts were not always calculated and decisions had not been made during the day if a person's intake was good, average or poor. This meant concerns were not noted or appropriate actions taken. We saw that where a person had lost weight, staff had been proactive in implementing a weekly weighing plan and seeking medical advice. This meant the provider had sought help for people who had lost weight.

We found the configuration of the ground floor unit had recently been changed. New doors had been constructed to separate general nursing and dementia units. Staff and relatives told us that the home's management had done this without consulting them and that they were very unhappy about it. A relative told us "There was no consultation about this. The whole dementia unit has been forgotten about; the whole focus is on the general nursing unit. People in the dementia unit have had their freedom restricted and we are very unhappy about it". One person said, "I am very unhappy that the doors are closed and people are being locked in. Before, they could walk around the building in familiar surroundings. Now they feel trapped. I've come in twice since the doors were put in and found my wife pawing at them to get out – she is confused. She has even walked into them a couple of times." One person told us their relative prefers to stay in bed all day; they said the new set-up was too much of a change. We saw staff throughout our inspection had to attend to people and assist in turning them around when they reached the doors. We found the adaptations to the premises did not meet the needs of people who were living with dementia.

We spoke with staff about the unit feeling unsettled, they said the dining room had been changed twice and people were used to watching TV in the space where they now eat. They also said people were confused about where to go. We saw people watching a large TV on the wall in the dining room. We spoke to the manager who said rooms had been changed to allow greater access to dining tables. One relative said, "The configuration of the lounges and dining room on this floor has changed for the second time and there was no consultation with us. Dementia residents are anxious and they seem distressed and confused. I've had a letter from the area manager apologising but this isn't good enough – how can she not be aware of what's going on? We asked a staff member why the dining room had been changed and they did not know, they said there was no staff consultation either and said. "Now there aren't enough seats for us all." We found the adaptation of the premises did not meet the needs of the people living with dementia.

On the upstairs intermediate care unit we observed people's files spread across two tables in the dining room and the staff on the unit were working from the dining room. We noted relatives talking to staff and asked why they were working from the dining room. They told us they did not have a confidential office space where they can talk with relatives, make telephone calls in private and store people's records. We noted people's records for an upstairs unit were located downstairs. This meant staff had to leave an upstairs unit to update records. During the inspection we observed people in wheelchairs brought along the corridor into the intermediate care unit and being returned with wet hair. We asked why this was happening. Staff told us the room where people get their washed was in the unit. We spoke to the registered manager who agreed the building required some changes.

We found a care worker sitting in a lounge with a person. The person was sitting in silence and the member of staff was texting on their mobile phone. We spoke with the person in charge about this they said, "The member of staff was actually on their break but there's nowhere for them to

Is the service effective?

use on that floor. She shouldn't have been using her phone so I've reminded her of the policy on this." We found the staff member appeared uncaring during their break as they had not used the available staff room.

We found the registered person had not protected people against the risk of the unsafe premises. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We spoke with the registered manager about what who told us having been in the service for six days they had yet to get to the bottom of this issue. They showed us a file where applications had been made. Following the inspection the registered manager sent us an updated table with a list of three people's names. We saw the applications had yet to be authorised. We spoke with staff about DoLS authorisations. One person said, "The slow rate of DoLS applications in this home are down to the change of management. The last manager did not allow any other staff to have access to a computer and so applications were only sent out when she had time. The new manager had promised the senior staff that we will have computers so we can speed up the rate of DoLS applications." We saw all staff had undertaken training in Deprivation of Liberty Safeguards.

We saw that all people living in Ashwood Park had undergone a 'consent to support' and Mental Capacity Act (2005) assessment to identify their capacity to consent to their care. In all cases we saw that a nurse had conducted a best interest's assessment, which allowed staff to decide the level of care they were able to provide to each person. Where people had been found to not have the capacity to consent to their care, staff had followed best practice and identified a suitable representative to support the person.

We talked with staff about training. One staff member said. "Yes, I have done all the training for level 2 and am now doing e-learning on medicines so that I get my level 3." Another staff member said, "Yes, we do training it is part of our job. I have level 2 and am going to do fire safety this afternoon. I have done my Moving and Handling, Infection Control, Falls – these all help to keep people safe." We looked at the training report for the home and found staff had undertaken e-learning appropriate to their role and delegated tasks. For example we saw senior care workers had undertaken training in the care of medicines, other staff had undertaken fire warden training. We saw staff had been trained in safeguarding, dementia, fire safety, first aid and infection control.

We found staff had not received supervision in line with the provider's policy. A supervision meeting takes place between an employee and their manager to discuss concerns and any training needs. We saw the provider's policy stated the frequency of supervision should take place at 'least every 4-6 weeks'. We found staff supervision had not taken place at this level, for example some staff had received one supervision meeting in the last year. We looked at the supervision notes and found the notes did not reflect discussions about people's training and its application to their practice. This meant supervisors were not ensuring staff learning was carried out in the workplace.

We found the registered person had not provided supported to staff through supervision. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Good

Is the service caring?

Our findings

We asked people if they were happy with the care they received. One person said, “Yes, I am happy with the support I get. I am able to do some things for myself and I am encouraged to do so. I have my meals brought to me; I get my medication brought to me. If I ask for anything to be done, then they do it. Yes, happy with the care I get.” Another person said, “Yes, I am happy with the care I get, I unfortunately cannot manage outside on my own. I am treated with great kindness by the staff and they will do anything you.” A relative told us, “We can’t fault them. They treat [relative] very well; she is always nice and clean. If we have a grumble it is about her getting the wrong clothes put on – I have told them about it. Everything she has is labelled; mistakes should not happen like that.” Another relative told us they thought the care a person received was "Wonderful".

We spent time observing people and staff found that staff spoke with people in a kind and reassuring way and that when people were confused, staff used appropriate means of communication to help them to relax. One person told us, “The staff have always treated me very kindly. I could not say a word against any one of them.” One relative told us, “If I thought for one minute my mother was not being treated with kindness, then I would make a complaint, but I must say I have only seen kindness.”

We found staff respected people’s dignity and closed their bedroom doors when they were delivering personal care. We observed staff ensured people’s skirts were pulled down to cover their legs. One person told us, “Yes they do treat me with respect. They listen to what I say and what I would like do. When I am getting a bath they make sure the door is closed and I am then able to wash as much of myself as I am able.” Another person said, “I have always been a private person. I am treated with respect. I want to retain my dignity as long as I am able, the girls respect that. I am encouraged to do as much as I can for myself which suits me admirably.”

We saw that staff had a good understanding of people’s needs. For example, staff knew when a person’s favourite TV show was about to start and reminded them, helping them to get ready for it. Staff members were able to give us information on people’s backgrounds. Although staff demonstrated kind and compassionate attitudes, we saw that they did not often have time to spend with people because they were so busy. This meant that throughout our visit we observed people sitting alone in lounges or walking around with no interaction or stimulation. As a result of this we noted the atmosphere in the home was not always calm and conducive to people’s well-being.

In the reception area we saw a desk which provided information to people, staff and visitors. The information included leaflets about the conditions people living in Ashwood Park were experiencing. This meant the provider was supporting people to access other services and give them information about their conditions.

We saw people’s bedrooms had been personalised with their private possessions and people were able to spend time in their rooms in private. This meant people were surrounded by familiar possessions which were important to them.

We saw the provider had in place an end of life policy. We talked to the manager about end of life care and the arrangements in place to support people. The manager explained the arrangements included working with staff who were specially trained to work with people at the end of their life. We saw Marie Curie nurses working in the home.

During our inspection we used a SOFI to see what people’s experiences were during a mealtime. We found people who were able to verbally communicate with staff were responded to whilst those who were not able to verbally communicate did not have any stimulus at the table. For example we heard staff respond to people who asked what was for lunch, but we observed a person not able to verbally communicate was sat at the table for half an hour without any staff interaction, a member of staff walked past them and they raised their head with a smile but did not get a response. We observed a table of three people who once they had been sat at their table did not communicate with each other or have staff communicate with them. The manager asked us for feedback on our SOFI and listened to our observations. They acknowledged further work was required.

Requires improvement

Is the service responsive?

Our findings

We asked four relatives if they would know how to complain to the provider. One relative said that they would speak to the manager but did not think it would be taken seriously and two relatives said they had never been given a copy of the complaint procedure and would just ask for a senior member of staff. One relative said "If there was something to complain about then we would. I have complained about the laundry not giving mam some of her clothes back, but they did appear later." One person said "I am not a complaining type of person. I would try to talk to someone, maybe the manager and try and resolve any problems. I have not had the need too but I would know how to make a complaint."

We saw the provider had in place a complaints policy and found where people had made complaints these had been recorded, the complaints had been investigated and outcomes given to the complainant. However we were aware of one relative having made a complaint which had not been recorded. The manager was unable to provide a reason as they had not been in post at the time of the complaint.

We spoke with people about getting the medical attention they needed. Both people and family members indicated staff pick up that the resident is not altogether well and if a doctor is needed they are called. One person said, "The doctor came to see me when I had an infection. I was given antibiotics, it is a while ago, and I got better." A family member told us, "We get told if (family member) is not well. The staff keep us well informed, I am pleased to say."

We looked at the care plans for seven people and found people were assessed prior to admission to see if the home could meet their needs. This had been carried out in the presence of relatives who contributed to the person's care planning. We saw people's care plans provided staff with information on people's needs including their eating and drinking needs, personal hygiene, bedtime routines and health needs. We found the care plans contained detailed information relevant to each person. We also found each person had in place in their care records a page entitled 'This is me' and a page entitled, 'My Day' which detailed a person's chosen morning, afternoon, evening and night activities. This meant staff could see details about the person's preferences on two pages. We saw staff on duty completing the daily records for each person in their care.

We also saw each care plan had evidence of the person's consent, or of their representative, for their photograph to be used in their care documents to help staff identify them. We saw that although the consent forms had been signed, the section that detailed what the photographs could be used for had not been signed or completed.

Care plans and associated risk assessments had been reviewed on a regular basis and there was evidence that staff had involved appropriate medical professionals in capacity assessments, including GPs, social workers and mental health specialists. It was not always clear who had read peoples' care plans. Each plan had a record sheet at the front for staff to sign to indicate that they had read and understood this. However in most cases these sheets were blank and in one case only one member of staff had signed it. This meant we could not be reassured all staff were to date with the care people needed.

During our inspection we saw people had in place an activities support plan with tick boxes to demonstrate a person's preferred activities. We found these had not been collated in the home to consider individual preferences. We also saw there was a board which detailed the activities on offer and we saw none of the activities on the days we visited had taken place. For example we saw on the board there was to be a sing-along which did not take place. We asked the manager why this was the case. The manager spoke to the activities coordinator and then responded to us by saying the activities coordinator had been told to put the board up by the previous manager. The manager was concerned a karaoke night had been arranged and found this might not fit with the needs of people using the service.

People spoke with us about their activities, one person said, "I am not into activities. I enjoy reading and watching certain programmes on the Television. I am content with what I do."

Another person said, "I like singing the old songs and sometimes we do that. A lot of the time I watch the television. We can play card games and they are alright. When the weather is nice I like being in the garden." A relative told us, "We bring in puzzles which mam liked to do. Half the time now she loses pieces or put them in her mouth. She can't do much." We found further work was needed to improve the activities on offer to people and to provide stimulation.

Requires improvement

Is the service well-led?

Our findings

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. During our inspection we found the registered manager had left the service and a new manager had been appointed. On the first day of our inspection the new manager had been in post six days. They expressed their intention to apply to become the registered manager.

We spoke to the new manager about our findings with regard to the premises during the inspection. They told us they could not disagree with our findings. They demonstrated to us the changes they had planned to make and showed us items they had bought for the bathroom walls to enhance people's experience of bathing. They had also introduced pet rabbits into the service and described to us the positive impact having pets had on people living in the home.

It was not possible to ask about the manager's leadership qualities in respect of Ashwood Park until they had the opportunity to have sufficient time to utilise the qualities and demonstrate improvements. However when we pointed out deficits in the home we observed the manager undertaking the discussions with the appropriate staff, questioning practice and exploring solutions to the problems. We found the manager was willing to start to address service improvements.

We raised concerns with the manager when we found 41 letters to staff advising them if they failed to complete their e-learning they were at risk of disciplinary action. Staff told us the previous manager did not allow them access to computers. We were concerned that staff were not supported to access e-learning and then threatened with punitive action. Following the inspection the provider told us there were lap tops available for staff and staff could access the e-learning from home if they wished to do so.

We also saw accidents and incidents had been monitored by the previous manager. The manager had checked for accident or incident trends which required changes to staff practices and found no changes were required.

We saw the regional manager conducted a monthly visit to the home and provided a visit report. The report outlined actions which were needed to improve the service and monitored the conduct of the service. For example the regional manager looked at the weekly and monthly audits of the service, laundry and kitchen audits and maintenance books. We saw actions were checked on subsequent visits and where necessary these were carried forward until the issue was resolved.

We also saw the service had a number of audits in place to check on the quality of the service provided. For example we saw kitchen audits had been carried out to check on the safety and cleanliness of the kitchen. We saw a food and mealtime audit had been carried out in January 2015. The audit required staff to offer people a chance to wash their hands before meals. During our inspection we did not observe this happening. This meant the action of the audit had not been carried out. We also found the audits carried out by the previous registered manager and the regional manager had not addressed the premises deficits we found during our inspection.

We found the new manager had begun their role by putting into place meetings with the staff and relatives. We saw minutes of these meetings where issues were raised and the manager responded with their plans to address the issues. However we found the provider had made changes to the environment without consultation with staff, people who lived in the home and their relatives. The relatives expressed dissatisfaction with the changes to the environment and the impact they had on people living in the home.

We saw the provider had carried out surveys of the people who lived in Ashwood Park and their relatives to seek feedback on the home. The results of the surveys were largely positive.

During our inspection we noted a number of other professionals working in the building. A room had been set aside for equipment used by occupational therapists and physiotherapists to support people who had been discharged from hospital. We saw district nurses and Marie Curie nurses working alongside staff. This meant the provider had arrangements in place to work with community services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not supported staff using supervision in accordance with their policy.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use the service were not protected from unsafe medicines practice.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises.