Runwood Homes Limited

Ashwood - Ware

Inspection report

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Ratings

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

Overall summary

Ashwood is a purpose built care home and is registered to provide accommodation and personal care for up 64 older people some of whom are living with dementia. At the time of our inspection 64 people were living at Ashwood.

The inspection took place on 23 and 25 September 2015. On the 25 we arrived early in the morning to inspect the service. Both days of the inspection were unannounced.

We previously inspected Ashwood – Ware in December 2013. During this inspection we found that the provider had taken action to improve staffing levels at the home and was at that time meeting the required standards.

The home had a registered manager in post who had been registered since October 2010. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

Summary of findings

associated Regulations about how the service is run. However at the time of our inspection the home was being managed by a temporary manager from another of the provider's homes due to the registered manager being absent from work.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Ashwood and a number of these were pending an outcome.

At this inspection we found there were insufficient numbers of staff deployed to provide care safely to people living in Ashwood. We found examples where people's health and wellbeing had suffered as a result of this.

Systems were not in place to monitor, review and investigate incidents and accidents to keep people safe from the risk of harm or abuse.

Risk assessments had not always been developed to positively manage risks to people, once staff had identified a change to a person's support needs.

People's medicines were managed and stored safely, and people received their medicines as they were prescribed.

People were supported by staff who had undergone a robust recruitment process to ensure they were of sufficiently good character to provide care to people.

We found that staff had not been supported by the manager or provider to enable them to carry out their role sufficiently.

People's nutritional needs were not always met or monitored. People were not able to freely choose what they ate and people's weights and dietary records had not been maintained.

People we spoke with told us they had access to a range of health professionals, and records demonstrated they were referred quickly when their needs changed.

Staff spoke to people in a kind, patient and friendly manner, however people's appearance meant they were not always treated in a dignified way.

People's wellbeing was not always supported by staff who provided care and support to them. They did not ensure that they were meeting their individual needs and preferences by ensuring people's social needs were met.

People did not always receive care that was responsive to their needs.

We found that Ashwood did not promote a culture that promoted support, fairness, transparency and an open culture. Staff morale was low, and at the time of our inspection, little had been done to address this.

People did not receive care that was well led and regularly monitored and reviewed to ensure the care was of sufficient high quality.

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? The service was not safe. There were insufficient numbers of staff deployed to safely support people's needs. Where people were at risk of harm, the manager had not sufficiently investigated and reviewed incidents to ensure people were kept safe. People's medicines were managed safely. Staff were recruited through a robust procedure to ensure they were of sufficiently good character.	**Inadequate**
Is the service effective? Staff had not been supported by the manager or provider to enable them to carry out their role sufficiently. Staff were observed to gain peoples consent prior to assisting them with tasks. Where people lacked capacity, their appropriate assessments had been carried out in line with the requirements of the Mental Capacity Act 2005. People were not always supported to eat or drink sufficient amounts.	**Requires improvement**
Is the service caring? Staff spoke with people in a kind and sensitive manner, and knew people's needs well. People were not always assisted to maintain a dignified appearance.	**Requires improvement**
Is the service responsive? People did not always receive care that was responsive to their needs. People's wellbeing was not always supported by staff as they failed to ensure that their individual preferences and social needs were met.	**Requires improvement**
Is the service well-led? People did not receive a good standard of service as systems and processes for monitoring and reviewing the service were ineffective. People's care records did not contain sufficient information to reliably inform staff. Reviews of peoples care needs were also insufficient	**Requires improvement**

Care Quality Commission

Ashwood - Ware

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 met 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 under the Care Act 2014.

This inspection took place on 23 and 25 September 2015 and was unannounced. We inspected Ashwood because concerns had been raised with us that suggested there was insufficient staff available to support people's needs. We were told that the registered manager had recently gone on long term leave, and the deputy manager had resigned.

The inspection team was formed of two inspectors.

Before our inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

During the inspection we observed staff support people who used the service, we spoke with ten people who used the service, 12 members of staff, the interim management team and a visiting health professional. We spoke with four relatives to obtain their feedback on how people were supported to live their lives. We received feedback from representatives of the local authority health and community services team. We also 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 reviewed care records relating to seven people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Inadequate

Is the service safe?

Our findings

People we spoke with gave us mixed views about their safety living at Ashwood. One person told us, "I feel safe, I`ve been here a long time."

People, their relatives and staff told us there were insufficient numbers of staff available to provide care and support to people. One person told us, "They do their best and all, but they don't have time to help me when I need them to." One person's relative told us, "Sometimes staff seem short and they always rush around." All the staff we spoke with told us they felt pressured, and stressed with the current staffing levels. Staff spoken with told us that they had been understaffed for a number of months, and the current staffing levels were insufficient to provide care safely. One staff member told us, "right now we can't give the care that people need because we are just dead on our feet with the pressure."

During our inspection we observed how staff provided care to people. We observed throughout the day that staff were rushed and provided care in a task orientated manner. One staff member told us, "It's hard; we have enough time to do the basics but can't give people the time they either want or need above this." We identified one person who was being cared for in bed and had recently developed a pressure sore while they were at the home. The person's care plan noted that they required repositioning in bed every two hours to reduce the risk of further skin breakdown. We asked one carer with the manager present how often the person should be turned. They told us, "We usually do it every two hours, but today I don't have anyone to help me." They told us they had only turned the person because a visiting health professional had assisted them as they had visited the person to change the dressing. Staff we spoke with told us that they had brought the issue of insufficient staff to the registered manager's attention, however their concerns had not been acted upon and staffing remained static.

We looked at how staffing levels were reviewed and altered to reflect the diverse needs of people living in Ashwood. The interim manager told us that monitoring tools used to assess and review dependency had not been completed since April 2015. The usual procedure was for the manager to assess the dependency of people, and discuss this with the regional manager to adjust staffing levels. We found, that the manager had not been reviewing and altering staffing levels to reflect the needs of people in the home and staffing remained unchanged regardless of people's care needs.

We looked at the staffing levels for night staff. Staff spoken with told us that it was usual for there to be three care staff and one senior care staff on each night shift. On the morning of the 25 September 2015 when we visited we found this was the staffing levels for the previous night. However, Ashwood is separated into six separate bungalows. Each member of care staff and a senior care staff cover a bungalow during the night shift. This left two bungalows that were unattended at periods. However, five people required repositioning frequently. Three people required repositioning two hourly and two people required repositioning four hourly. This meant two care staff were regularly required to reposition and subsequently assist and settle people throughout the night. This left one carer and one senior available to attend to all the needs of other people. In addition, night care staff were required to complete the day's laundry. One staff member told us, "We have to do the laundry and provide cover in the three bungalows between two of us, it's just nuts." A second staff member told us, "When it's busy, people have to wait." We looked at the repositioning charts for people, and saw that people had not been repositioned as required. Due to insufficient staffing numbers, people had been placed at risk of harm. Staff were unable to sufficiently carry out their duties, and as a result people's needs were neglected. We have referred our findings to the local authorities safeguarding team.

This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, subsequent to our inspection the interim management had been reviewing the staffing levels in the home regularly and had increased the frequency of reporting to senior management. The regional manager told us that if the dependency tool demonstrated that additional staff were required, then this would be implemented immediately.

We looked at how incidents and accidents were managed in the home. We saw that where an incident had occurred, staff had completed the appropriate form which had then been reviewed by a member of the management team. The manager then reviewed the incident and took appropriate

Inadequate

Is the service safe?

actions, and if required referred the matter to the local authority. The manager maintained a list of some falls that had occurred in the home; however these did not always record incidents that had occurred. For example a person who had recently moved into Ashwood had fallen twice. When we looked to see if a record had been made we found it hadn't. This meant that systems in place to monitor review and investigate incidents and accidents had not been robust to ensure people were kept safe.

We reviewed body maps completed by staff and we found that unexplained bruising and injuries were not investigated by managers and were not reported to the local safeguarding team. For example we found that one person's body map detailed two bruises on the person`s stomach in July 2015 and a further bruise to their hand in August 2015. We found that managers had not monitored, recorded or followed up this incident sufficiently to safeguard the person. A second person's body map detailed two injuries in May 2015 and a further symmetrical bruise on their left and right arm below shoulders, and skin tear on their right arm in August 2015. Again we noted that managers had not monitored, recorded or followed up, this incident sufficiently to safeguard the person.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoken with about protecting people from abuse were able to describe to us what constituted abuse and what signs they looked for when supporting people. One staff member told us, "I complete an incident form and report it to the CTM, if they are not available then I report any worries to the manager." There was a range of information available to people and staff informing them of about abuse processes and who to report this to. Staff we spoke with were aware they could report their concerns to both the local authority and CQC. Staff were clear about their responsibilities towards whistleblowing, and each staff member spoken with told us they would not hesitate to report their concerns to either the manager or local authority and CQC. We saw that incidents, injuries and bruising had been documented in people's care records and an incident report had been written, however these had not always been thoroughly or investigated by the management team. One staff member told us, "If I ever thought for one minute that one of the staff had harmed or mistreated one of the residents then I would instantly tell the manager, council, you [CQC], Police or whoever I needed to."

However, when we looked at how incidents were reported and investigated we found that not all staff acted to keep people safe. For example, one person at risk of falls had a sensor mat in their room that sounded an alarm when stepped on to alert staff. This had been noted as not working and reported for repair or replacement. However, on the second day of our inspection, two days later this had still not been replaced. Staff had not increased checks for this person to ensure they had not fallen whilst repairs were made or a replacement mat was found. We confirmed this with the senior on duty who once again said they would raise this with maintenance.

Risk assessments had not always been developed to positively manage risks to people once staff had identified an area of concern. For example for one person who had sustained a number of falls and slips in the previous two months. Where they had fallen, updates had not identified the change the person had experienced in their mobility needs. In addition, the provider's policy relating to falls required that after each fall a 24 hour observation record was to be completed to observe the person closely in case these falls had caused any pain or injury which was not obvious at the time when the fall occurred. We found that these had not been completed where required. We spoke with one person who had recently experienced a fall. They told us, "I am not happy here, I had a fall. I don't feel safe. I am extremely nervous."

The staff used a range of assessment tools to determine varying areas of risk. For example, staff used a Waterlow score which gave an estimated risk for the development of a pressure sore in a given person. We found that some of these scores had been incorrectly calculated. This meant that people who were at high risk of developing a pressure sore were in fact assessed as medium risk. The interim managers told us they were aware that assessments such as people's Waterlow and mobility needs were areas that required reviewing. They had identified this prior to our inspection as an area to review, and were in the process of undertaking this.

There were suitable arrangements for the safe storage and management of people's medicines. Each person had a completed medicine administration record (MAR) which

Is the service safe?

recorded the medicines that people were prescribed and when to administer these. There were no gaps or omissions in the MAR, and staff maintained an accurate stock count of medicines with frequent stock counts. People were encouraged where possible to manage their own medicines and an assessment had been carried out to ensure it was safe to do so. The temperature of both the medicines room and fridges was monitored which ensured that people's medicine were stored within safe temperature limits. Where stocks were received and disposed of, accurate records were maintained and checked by two staff members for accuracy. People's MAR's were complete with an up to date photograph which ensured staff could identify the person correctly prior to administering their medicine. This sheet also contained details about people's allergies such as penicillin or food allergies.

However, one person was seen to be sat at the breakfast table with five tablets in front of them. The staff member had signed the MAR to say the tablets had been administered, however the person had not taken them at that time as they were eating their breakfast. This was in a communal area, where other people were present and could easily have picked up the tablets thinking they were their own. One of these tablets was an analgesic drug. This meant that this person's medicines had not been administered safely.

We reviewed recruitment records for three staff members and found that safe and effective recruitment practices were followed which ensured that staff did not start work until satisfactory employment checks had been completed. Staff we spoke with confirmed that they had to wait until the manager had received a copy of their criminal record check before they were able to start work at the home. This ensured that staff members employed to support people were fit to do so.

Is the service effective?

Our findings

People told us they thought the staff were well trained to care for them. One person told us, "I think we have the best carers in Ware." A second person told us, "I keep them in line if I need to but overall they are a really good bunch who know what they are doing."

Staff told us that they received effective training which ensured they were provided with the appropriate knowledge and skills to care for people. Newly recruited staff members completed an induction programme and shadowed an experienced staff member until they had been assessed as competent to lone work.

However, staff we spoke with told us they felt unsupported by the registered manager. Staff spoken with told us they felt recently they were unable discuss their role or any difficulties which the registered manager. One senior member of staff told us, "The last supervision I had was June, then the manager left at the end of August, and the Deputy resigned in September. It would be nice to have more support, when the manager was here they just stopped listening, so we stopped saying. The new temporary manager [Name] is good, they are listening and I feel we are getting better." A second staff member told us, "Morale is so low, we are all pushed to the maximum with no gratitude or thanks, no one listens to us, and nothing changes." We saw that supervision records for staff were out of date and at the time of the inspection, staff were undergoing a change to their working pattern which had exacerbated their feeling of being unsupported. One staff member told us, "I get that we need to change the way we work, but just for a bit stop punishing the few staff left who by supporting each other keep this place going."

We found that staff had not been supported by the manager or provider to enable them to carry out their role sufficiently.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed to gain people's consent prior to assisting them with tasks such as eating, personal care or continence needs. Staff ensured they clearly explained to people what they needed to do, and waited for the person to respond. If the person was unsure then staff explained once again and waited for the person to agree.

Staff told us they had received training about the MCA 2005 and DoLs and that they understood what it meant. Staff were able to describe how they supported people to make their own decisions as much as they were able as with their personal care and daily choices. We saw that records of assessments of mental capacity and 'best interests' documentation were in place for people who lacked capacity to make their own decisions. The interim management team demonstrated a good understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. At the time of the inspection we found that applications had been made to the local authority in relation to people who lived at Ashwood and were awaiting an outcome.

People gave mixed views about the food provided at Ashwood. One person told us, "The food is very pleasant; the cook does a good job with what they have." One person said, "If you can talk then you can have a choice, but if your one of the people who can't say what they want then you're getting what they give you."

People's breakfast was not served according to people's own preference. For example, on both days we inspected people were provided with cereals and toast. One person told us, "At home I had eggs, but here I get them very rarely." We asked one staff member if people were able to have a cooked breakfast if they wished. They said that people were allowed a cooked breakfast on a Tuesday and Saturday. We asked what happened if people wanted to have a cooked breakfast on a Sunday. The staff member told us, "No, not on a Sunday, just on a Tuesday and Saturday." When we raised this with the interim manager they were unaware but told us it was not a practice that Run wood Homes promoted. They said that they would inform the cook they were able to cook a variety of breakfasts when people requested a cooked breakfast.

The staff in the kitchen were knowledgeable about people`s dietary needs, however they told us that the suppliers contracted by the provider were not catering for special diets such as diabetes. They told us they were buying products to support these needs from supermarkets which then put a strain on their budget. They felt they were not supported by the registered manager and were under pressure to keep within the budget.

We observed staff support people at lunchtime and found that people were not always supported to eat or drink sufficient amounts. For example, we saw one person who

Is the service effective?

was restless eat a few bites of their own meal and then get up and leave the room. They returned soon after and sat in another person's chair that had also left the dining room. By the time they came back the other person had eaten their dinner so they had to have their pudding. We then observed a second person who needed assistance with their meal had to wait for 25 minutes until the staff member had finished assisting another person. By the time staff assisted them the lunch was cold and they refused it. No alternative was offered and the person only had their pudding.

We found that one person who was nursed in bed since April 2015 had not been weighed at all and staff made no attempt to establish if the person had lost any weight since. We asked staff if the person had been losing weight and the had confirmed that since they were declining in health they observed the person getting thinner, however they could not tell us the exact weight of this person. However, staff were unaware of other methods they were able to use to estimate a person's weight such as arm circumference. This left this person at risk of malnutrition because staff were unable to monitor their weight loss effectively.

People who lost weight or were at risk of losing weight were referred appropriately to dieticians and speech and language therapists (SALT). People were weighed regularly and had a food and fluid chart in place which was monitored daily. However charts we looked at were not all completed in a consistent way so it was difficult to gauge how much someone had actually eaten. This would make it more difficult to assess people's dietary intake if they were at risk of weight loss.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us they thought the care staff were sensitive and caring. One person told us, “[staff] is gentle and soft with me. I am never made to feel uncomfortable by them when they help me.” A second person told us, “Caring, yes very much so, but they are worked like dogs and need a bit more time.”

We observed throughout our inspection that staff spoke to people in a kind, patient and friendly manner. Staff took time to acknowledge people and understand their needs and how to respond appropriately. For example, we heard one person, who was clearly agitated and upset say to a staff member that they wanted to go home. They said, “I need to go home to my wife, I love her very much. One care staff member responded, “Stay with us for a little while, we love having you here. I am sure your wife loves you too.” The person was seen to be soothed by this and contently went about their day less troubled.

However people were not always treated in a dignified manner. Where people were supported with their personal care, they were quietly taken to the bathroom or bedroom where staff sensitively supported people behind closed doors. However we also observed that people looked as if they had not had their hair washed and combed and appeared dishevelled with clothing that was unclean. For example, we observed one person who spent a large proportion of the day with us. After breakfast they were seen to have spilled some cereal down their top. Their top was not changed, and progressively became more soiled as the day progressed. It was finally changed when one staff member noted the staining and gently encouraged the person to their room. A second person was fast asleep in a chair in a communal area. Their T-shirt was visibly too tight and short. It had risen above their stomach exposing their bare skin which was in everybody`s view who entered the home. We saw one person had been unevenly shaved. They had patches of hair that was longer in places and looked uneven. The person told us, “Staff are supposed to give me a wet shave but they are not doing it. I am doing my best with the electric shaver but it’s no use if my beard is too long.”

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they did not always feel involved in making decisions about their care. One person told us, “We have a good natter now and then about my health, things like my feet and eyes, and I tell them what I need and they get on with organising things.” However, other people did not feel involved. One person said, “It’s just questions, don’t matter what we say because they will just do their own thing in the end.” One person’s relative told us, “So many times I have raised the point that I would like my [relatives] top changed when they had food stains after meals and very often it is not done. I also asked staff to sit them in a proper chair, I don’t want [relative] to feel different from others and I know they don’t do it because the wheelchair is covered in food.”

People told us that they didn’t always have a choice about when they went to bed or when they got up. We saw in one bungalow that five people were sat at the dining tables. Two of these people were asleep and the other three were watching the television whilst waiting for their breakfast. We asked them all whether they wanted to be up at that time. Two people told us that they had rang the bell for assistance, and whilst staff provided them with personal care they may as well get them up for the day. The two people who were asleep later told us they were rarely able to have a lie in when they chose to. Night staff we spoke with told us that people were put to bed earlier than they would like, and that when people woke up in the morning then they got them ready for the day. They said that the reason for this was because of staffing shortages. Day staff we spoke with told us that staff did not wake people up, however if people were awake then they were changed and got ready for the day. People therefore were not involved in making decisions and not able to choose how to spend their day.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

People told us they mainly watched the television as there was never much going on that interested them. One person told us, “I sit and watch TV all day because it is nothing else to do. I can only go out if staff take me in the wheelchair and they won`t.” Another person said, “I sit and watch TV nothing else. I have one friend and we chat to each other at times, but I am not getting up early today as there is nothing to do.”

One person’s relative told us that activities were mainly in the front room of the building. They said that staff did not always take people there. They said, “It seems activities are done just in one place so [relative] will miss out because they don’t want to move. It would be nice to have activities organised in the bungalows as well. It is a shame as no trips are organised lately and [relative] doesn’t really want to participate in anything else. [Relative] would love to be taken out shopping and stuff.”

People’s care records confirmed that staff had not provided them with individual activity or supported them to pursue their own hobbies or interests. Those people who were unable to walk unaided had not been taken out to the local town to go shopping, or leave the home, unless accompanied by their relative. Staff we spoke with told us that the pressures placed upon them due to poor deployment and insufficient numbers meant they were unable to support people the way people needed and in a way they wanted to. One staff member told us, “They [management] seem to think care is about washing, dressing and feeding people and that’s it. There are activities in the lounge, but that’s not for the people in bed, and we are so busy we can’t spend time doing the nice parts of the job like paint someone’s nails or sit talking about their families.”

We saw there was an activity schedule in place, and activities were taking place in the lounge area. On the day of our inspection, the activity staff were throwing a ball to people. Two people obviously were not used to this activity as they were unaware the ball was thrown and when it hit them on the head they looked startled and alarmed. In the afternoon, a musician was brought in who played the piano and encouraged people to sing along. However, not even half the people in the home attended. Those who were not able to attend listened from their bedrooms but were unable to join the activity. One person told us, “Sounds like they are having a lovely afternoon, but never mind, I can hear from here alright, but maybe I would have liked to have been asked.”

This meant that peoples wellbeing was not supported as the provider did not have adequate arrangements in place to ensure peoples social needs were met.

People did not always receive care that was responsive to their needs. We saw from records we looked at that people did not always receive the care they were assessed as requiring. For example, one person was placed under close observation by staff with half hourly checks in place to monitor their behaviour because their behaviour placed themselves and others at risk. However, when we looked at the observation records, we found the last time the check was recorded as being completed was 07.30 that morning which was three and a half hours prior to when we checked the record. The person was observed throughout the inspection to be restless and agitated and paced the corridors of the home constantly. As staff were increasingly busy they were unable to provide both the level of supervision required or the appropriate intervention to support the person.

A second person, who developed a pressure sore, was required to be repositioned every two hours. When we checked the repositioning charts we found they had not been repositioned regularly both through the night and on the day of our inspection. This person had already developed a pressure sore in Ashwood and was left at risk of developing further pressure sores due to them not receiving care that was responsive to their needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us the staff listened to them and responded to their concerns and, “Niggles,” as one person put it. They said that the staff would, “Try their level best to get things right.”

People’s relatives we spoke with told us they were not able to recall any meetings taking place for them to raise concerns or discuss the service. One person said, “We don’t have any meetings here. If I have a complaint I will go in the office.” One relative said, “I feel confident in raising any issues I have with management. It was just one occasion I saw a staff member who I did not see before and they were

Requires improvement

Is the service responsive?

raising their voice to people. I have not seen them since." They told us they felt satisfied with the response from the manager and reassured by this that their concerns were listened to.

All the people we spoke with told us they knew how to make a complaint, and from records we looked at saw that the manager had investigated and responded to complaints appropriately. Information was made available to people once they moved into Ashwood, and a range of information and advocacy services to support people with a complaint were available.

Requires improvement

Is the service well-led?

Our findings

We found that Ashwood did not promote a culture that emphasised support, fairness, transparency and an open culture. Not all people who used the service and their relatives were aware the manager was on extended leave, or that an interim manager was in post. They told us that the registered manager was not always approachable or supportive. One person said, "Staff morale is very low, it would be nice, just now and then to have a bit of recognition for the work we do. We used to go to [manager] and raise our concerns, such as completing the paperwork or needing more staff, but they never did anything about it so now we don't bother. The temporary managers seem to listen a bit more to us, so we'll see what happens." A second person said, "There is only so much pushing we can all take. Nobody listens to us, and nothing changes, and now the manager is off. Staff are leaving, and it's the good staff that are going, and even now they don't listen and punish us further by changing our hours."

Staff told us the recent difficulties in the home had created a negative and oppressive atmosphere. One staff member said, "I used to love it here, it's being with the elderly that I enjoy, but the management make it stressful and tiring to the point where I may end up leaving."

The provider organised an independent review of the quality of care at Ashwood to be carried out in June 2015. The assessment had rated the quality of service asking the same five key questions that we ask during our inspection. Safe and Responsive were rated as requiring improvement. This was because of areas such as ensuring food and fluid and turning charts were completed, and to record, document and provide more opportunities for people to be socially involved in the home. We were unable to find any action plans that addressed these concerns, and subsequently found the same issues were present when we inspected three months after this review. We asked both the interim and regional manager to provide us with an action plan detailing how these issues were to be met, however they were unable to provide us with these when requested. Due to the absence of the registered manager, it was not possible to locate all of their documentation.

Staff we spoke with told us they had raised the issue of staffing with the manager. We saw that the manager was required to complete a regular dependency tool and submit this to the regional manager to review staffing levels. However, when we asked for a copy of this tool to be provided to us, the interim manager was unable to locate one. We asked the regional manager why the tool had not been submitted and reviewed and why they had not considered this a risk. They told us that if the manager had not submitted their staffing dependency need, then this indicated there were no concerns. We asked the regional manager if staff who were concerned at the potential lack of staffing may have had a valid point, if the management team had not reviewed the dependency needs of people to determine the staffing levels. They agreed that the staff may have a point and would ask the interim management team to revisit this.

We looked at how the provider monitored the home through auditing and reviewing the quality of service. The interim manager and regional manager told us that a compliance visit was carried out monthly. They said this was completed by a senior member of the management team. We saw from records of visits previously carried out that areas such as staffing, care planning, medication, falls, weight loss and pressure ulcers were reviewed. We looked at the last review completed in July 2015. This provided us with little insight into how the auditor had compiled the report. For example the report noted that, "Staff know the needs of the residents," however nowhere in the report does it reflect on comments made by staff to this effect. An action notes a nutritional chart is required to specify the amount of food taken e.g. full portion, quarter or half. However, again the findings in the report do not reflect that this was an identified concern. Where actions had been listed, they were not attributed to any one person, and no date for review was given. We saw that the most recent compliance visit carried out on behalf of the provider was completed by the home's administrator. This meant that identified actions to improve the service were not implemented.

It was clear that the manager had not identified the concerns raised by the staff, and no plans had been developed by the registered manager to address these. The interim managers however were able to tell us how morale was impacting negatively the residents, and demonstrated to us how they planned to address this in the coming months.

People's care records when reviewed did not always contain sufficient detail to provide a comprehensive account of a person's needs and care. Care plans did not

Requires improvement

Is the service well-led?

always contain sufficient information about a person's life history, needs or preferences, and had not always been sufficiently reviewed when required. People's food and fluid records were not sufficiently maintained, and records relating to people's weight and nutritional needs were incomplete. This meant that staff had not maintained an accurate, up to date record of people's care needs.

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

However, subsequent to our inspection a senior member of management for the provider visited Ashwood – Ware and submitted to us a comprehensive action plan that addressed the shortfalls that we identified through our inspection. This plan detailed the areas that required improvement and timescales for the completion of each area. This meant that although the systems and monitoring processes used to keep people safe had not been effective, the provider had taken action when these were identified.

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (3) (d) (e) People were not supported to make choices about the care or treatment they received, and were not provided opportunities for to make decisions relating to their care and welfare needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Dignity and respect** Regulation 10 (1) People were not always treated in a dignified manner.

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 **Safeguarding service users from abuse and improper treatment** Regulation 13 (1) (2) (3) Systems in place did not identify and report unexplained bruising and injuries and were not investigated by managers to ensure people were not at risk of harm or abuse. Where required, notifications had not been made in relation to these.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance** Regulation 17 (1) (2) (a) (b) (c) The provider had not ensured systems or processes that were established were effectively used to monitor and improve the quality of services people received, and to keep people safe. An accurate contemporaneous record had not been maintained in respect of each person relating to the care and treatment provided to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing** Regulation 18 (1) (2) (a) There were insufficient numbers of staff deployed to safely provide care to people. Staff did not receive appropriate support, and professional development, to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Meeting Nutritional Needs** Regulation 14 (1) (2) (3) (4) (a) (d) People were not always supported to eat or drink sufficient amounts.

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.