Hendon P.I.F. Limited

Ashwood Court Care Home

Inspection report

Ashwood Court
Suffolk Street
Sunderland
Tyne And Wear
SR2 8JZ

Tel: 01915659256

Date of inspection visit:
14 December 2017
04 January 2018
22 January 2018

Date of publication:
12 April 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

This was an unannounced inspection carried out on 14 December 2017 and 4 January 2018.

This was the first inspection of Ashwood Court since it was registered with the Care Quality Commission in May 2017. It was previously registered under a different legal entity.

Ashwood Court is registered to provide personal and nursing care to a maximum of 30 older people, including people who live with dementia or a dementia related condition. At the time of inspection 27 people were using the service.

Ashwood Court is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment, staffing levels, staff training, person-centred care and governance.

Although people told us they felt safe, systems were not in place to keep people safe and to provide consistent care to them. Strategies were not in place to support distressed behaviours effectively. Risk was not well-managed. There were insufficient staff to meet people's needs.

Care was provided with kindness but people's dignity was not always respected. People did not all receive a varied and nutritious diet. We considered improvements were required to people's dining experience. There were limited activities and entertainment available for some people. We have made a recommendation about this.

Improvements were required to staff training and staff supervision to ensure people received safe and

effective care. Staff knew people's care and support requirements. However, record keeping required improvement to ensure it reflected the care provided by staff.

A robust quality assurance system was not in place to assess the quality of the service. Audits that were required were not all carried out and some that were carried out were not effective as they had not identified issues that we found at inspection.

People were able to make choices about aspects of their daily lives. They were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice. However, we have made a recommendation about best interest decision making and medicines management.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Staff told us communication was effective within the service.

Changes had been made to the environment. Some areas had been refurbished. However, not all areas of the home were clean and well maintained for the comfort of people who used the service. The home was not all designed to promote the orientation and independence of people who lived with dementia, although plans were in place to address this. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

A complaints procedure was available. People had access to an advocate if required. Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

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?

Requires Improvement

The service was not safe.

Risks to people were not always well-managed. Systems were not all in place for the management of distressed behaviours.

Staffing levels were not sufficient to ensure people were looked after in a safe, effective and person centred way. Staff had received training with regard to safeguarding. Staff were appropriately recruited.

Checks were not always effective to ensure the building was safe and fit for purpose. Areas of the home required more immediate attention as they were not clean and they were showing signs of wear and tear.

People received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was not effective.

A programme of refurbishment was taking place around the home. Improvements were planned to ensure it was designed to promote the orientation of people who lived with dementia. We have made a recommendation this.

A system of supervision was not in place for clinical staff. Staff were not all appropriately trained. Support staff received supervision and training to support them to carry out their role.

People did not always receive a varied and balanced diet. We have made a recommendation about this. Support was provided for people with specialist nutritional needs but improvements were required to the organisation of people's dining experience.

Best interest decisions were not all made appropriately on behalf of people, when they were unable to give consent to their care and treatment. We have made a recommendation about this.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and cheerful.

Staff were aware of people's backgrounds and personalities. Good relationships existed and staff were aware of people's needs. Improvements were required to respect people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff.

Staff in some areas of the home did not always engage and interact with people except when they provided care and support. There were limited activities and entertainment available for some people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance system was not robust. More regular checks needed to be carried out in some areas. An external quality assurance system was not in place to check the effectiveness and safety of the service.

A registered manager was in place. Staff and people told us the management team were supportive and could be approached for advice and information.

Ashwood Court Care Home

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 14 December 2017 and 4 January 2018 and was unannounced. Further information requested as part of the inspection was received on 22 January 2018. The inspection team consisted of one adult social care inspector and one expert-by-experience on the first day and two inspectors and an expert-by-experience on the second day. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection we reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care and the local authority safeguarding team.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 16 people who lived at Ashwood Court, eight relatives, the registered manager, one registered nurse, nine support workers including one senior support worker, one member of catering staff and two visiting social care professionals. We observed care and support in communal areas

and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and induction records for six staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Our findings

Our observations during the inspection showed there were insufficient numbers of staff available to keep people safe and provide effective care to people in all parts of the home, especially to the top floor.

Not all people, relatives and staff expressed the view that people were kept safe. One person told us, "It's night time when I need help most, but staff are always very busy." One relative said, "I can't see how they can manage to keep everyone safe, the layout of the corridors is not helpful and I have only seen one member of staff since I've been here." A second relative commented, "I don't feel confident leaving [Name] here, we are looking to move them elsewhere." Other relatives comments included, "There seems to be a lot less staff at weekends and they are short staffed through the week", "I think due to lack of staff, there is often only one carer on the floor", "There are a lot of agency staff, they come and go" and "I worry as they are often short staffed here."

There were 30 people living at the home at the time of inspection. The registered manager told us two support workers supported 15 people who lived with dementia, or a dementia related condition. On the ground floor seven males, some with complex needs, on one unit were supported by one senior support worker. Eight people, on a separate unit, were supported by two support staff. A registered nurse supported both floors of the home. Overnight staffing included one registered nurse and four support workers.

The registered manager told us a staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. However our observations, care records, people's comments and the numbers of accidents and incidents showed there were not sufficient staff to keep people safe and provide person centred care.

The layout of the top floor and the usual staffing levels meant it was difficult to supervise people and keep them safe. There was a small lounge which could accommodate five people, a lounge area that was part of the dining room and could accommodate two people. Corridors were equipped with seating, due to the lack of communal areas for people to sit in on the top floor. This meant people who spent time in the corridors and were at risk of falling or distressed behaviours were not supervised as they moved around as staff were not available in this area. For one person who was at risk of falls we noted they had sustained two recent unobserved falls within a week whilst in the corridor. We observed on the second day of inspection that some people were still eating breakfast at 11:15 am as they had just been assisted to get up, as staff told us they were still busy helping people to get up at this time. We were concerned as lunch was served at

12:30pm that there was not much of a gap in between meals if people had small appetites and needed to be encouraged to eat their food.

We observed on the first day of inspection a member of staff on the top floor who was allocated to provide 1:1 care to a person also provided supervision and support to four other people in the dining area when staff were not available. Records showed some people had complex needs, distressed behaviours or were at high risk of falls. On one unit care plans showed people had allocated time to speak with the staff member in the evening, however one person people told us this was interrupted if another person required staff assistance. Several people had physical needs where records detailed two members of staff were required for support so this meant when the two staff members were busy in bedrooms or bathrooms assisting them other people were left waiting or unsupervised if they required assistance. The safeguarding log also showed there had been several incidents of service user altercations.

On the second day of inspection we observed staffing levels had been increased as a third support worker was working on the top floor to ensure people's care and support needs were met more effectively. After the inspection we were told an additional member of staff was to be allocated to help on the ground floor to cover both units. However, staffing levels needed to be consistently maintained to ensure they met people's needs.

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

Detailed information was not available for the management of distressed behaviours. Some people with distressed behaviour were referred to the positive behaviour team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague for some other people who may show agitation or distress. They did not give staff detailed instructions with regard to supporting the person. Information was not always available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour. For people who were prescribed 'when required' medicine for agitation or distress their care plans did not provide guidance to staff when the medicine may be administered so that it only to be used as a last resort to calm the person.

Most risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant and reduced risk to people's safety. They included risks specific to the person such as for falls, pressure area care and nutrition. However, written information was not available with regard to the management of alcohol or the risk of self-harm or other risks associated with mental health in order to minimise risk to the person's well-being. Records showed an incident had taken place with a person when they left the building overnight which placed them at risk of harm, records were not available to provide guidance to manage the risk. The outcome of the incident had not been recorded within the person's records to ensure consistent and appropriate care.

Not all areas of the home were clean. We noted there was a malodour around the home which was also evident in the kitchen/dining areas on the top floor and the ground floor kitchen on the unit identified at inspection. Some areas were showing signs of wear and tear. The walls were dirty in the top floor kitchen and the kitchen bin was left open. The kitchen floor covering in the main kitchen was damaged with the seals of the linoleum broken. The floor covering was damaged in the pantry which were an infection control hazard. Some kitchen tiles were broken by the kitchen door although they had been temporarily covered over. Some communal bathrooms and en-suite lavatories also required attention and some floors and walls

were marked.

Mattresses in some bedrooms were also marked and beds were not always made up and rooms tidied for the comfort of the person. We also observed towels were either not available in people's en-suite bathrooms or they were out of reach for the person. We were told a towel would be available in the morning for a person but we considered one should be available at other times of day for the person's use.

A system was not in place to show that lavatories were checked. We observed that hand soap dispensers and paper handtowels were not all restocked. One person told us, "The toilet is often left in a dirty state." A relative said, "Quite often the crockery and cutlery is washed in the sink and not in a dishwasher." Another relative commented, "The chairs smell." We were told two domestics were on duty each day from 8:00am-4:30pm. However, on the second day of inspection only one domestic person was on duty to try to ensure a satisfactory standard of hygiene around the building as a replacement had not been rostered to cover for absence.

Records showed that the provider had arrangements in place for the maintenance of the building and a maintenance person was employed. Maintenance work around the home was not completed in a timely way for the safety and comfort of people. For example, we noted some en-suite bathrooms had no light as light bulbs required replacing. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. However, the kitchen door did not close to its rebate and this was a fire hazard. We noted the fire authority were carrying out an inspection on the second day of our visit. An enforcement notice was served by the fire authority as the provider had not carried out some fire requirements from their visit in September 2017 to ensure the building was safe to minimise the risk of fire. After the inspection we liaised with the provider and fire department who told us action was being taken to comply with the fire safety notice.

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

External contractors carried out regular inspections and servicing. For example checks of fire safety equipment, electrical installations and gas appliances. We also saw records to show that equipment used at the home was regularly checked and serviced such as for the passenger lift, hoists and specialist baths.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

An analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. We saw sensor equipment was obtained for people who fell more frequently. This was to alert staff if people moved without support when they were at risk of falling.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. One staff member told us, "I'd report any concerns straight away." We saw the registered manager made alerts to the local authority and investigated all concerns.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were

responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were stored securely within the medicines trollies and treatment room. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place on the ground floor for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. We observed the controlled drugs cabinet to the top floor was broken so it was not in use. The registered nurse told us arrangements were in hand for it to be repaired.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories.

Requires Improvement

Our findings

Staff were not all appropriately trained to carry out their role. A staff training matrix showed that not all staff were kept up to date with safe working practices. For example, safeguarding adults, moving and positioning and infection control. We did receive information after the inspection to show that was improving and more staff had received updated safe working practice training. However, all staff had also not received training with regard to Mental Capacity and Deprivation of Liberty safeguards. Although the matrix showed a range of courses were available to ensure staff had the knowledge to meet individual peoples' care and treatment needs, very few staff had received such training. For example, nutrition, Autism, Asperger's Syndrome, dysphagia(swallowing difficulties), pressure area care, falls awareness and end of life care. Records showed the home provided care to some people with mental health needs. Staff told us and the staff training matrix showed staff had not received training with regard to mental health. For example, Korsakoff's (brain damage commonly associated with alcohol abuse), personality disorder, obsessive compulsive disorder, self-harm and schizophrenia to give staff some understanding of these needs.

The staff training matrix and feedback from staff showed staff had not received positive behaviour training to give them some insight into the management of distressed behaviour. Training would help to prepare staff and provide the knowledge to support people with distressed behaviour and recognise signs to de-escalate any potentially unsafe situations. Staff had also not received management of potential and actual aggression before they started working with people in order to provide safe care in potentially physically challenging situations. The registered manager told us the service operated a 'no restraint' policy. However we were told and records showed that some staff were subjected to physical attacks from some people when they were distressed. Training would provide staff with knowledge of a proportionate response of control or restraint or when there was risk of serious harm to the individual.

Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. One staff member told us, "I shadowed other staff for three days when I started." However, new and existing staff did not study for the Care Certificate as part of their induction to increase their skills and knowledge in how to support people with their care needs. The Care Certificate was designed to provide a standardised approach to training for new staff working in health and social care.

A system was not in place for clinical staff to receive supervision to discuss their professional development, work performance and training needs.

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

Support staff received regular supervision from the management team to discuss their work performance. One staff member told us, "I get supervision from the registered manager or the clinical lead." Another member of staff said, "The registered manager does my supervision every month." Non-clinical staff said they were supported to carry out their caring role. All staff told us they could approach the registered manager to discuss any issues.

Staff told us they received some opportunities for training. One staff member said, "There are opportunities for training." Another member of staff told us, "I've just finished dementia care at level three and medicines training." Other staff comments included, "We do face to face and e learning training" and "There are some opportunities for training."

Some redecoration of the home was taking place. Some communal areas and bedrooms had been decorated. The manager showed us an area of work that had started on the top floor corridor to create a themed area of interest for people. We considered more work was required with the environment to ensure it was "enabling" to promote people's independence, orientation and involvement. Pictures and signs for people to identify their bedroom were not all in place to help maintain their independence. We observed on the top floor room numbers had been painted in very large red numerals on the floor outside of some people's bedrooms. We were told the numbers had been there for some years, as they were worn they were not easy to read but we were told they were used for identification. We considered they were unsightly, red numbers randomly painted along the corridor floor and not all people would be able to recognise the numbers to identify their bedrooms in this way.

Memory boxes were not available that contained items and information about people's previous interests to help them identify their room. They would also give staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves. We discussed this with the registered manager who told us the environment was going to be designed to ensure it was stimulating and therapeutic for the benefit of people who lived there.

We recommend the service finds out more about current best practice regarding the design of accommodation for people who live with dementia referring to NICE guidance quality statement 7.

People were not all positive about the food. One person told us, "The meals aren't very good and I didn't want what was offered today." Another person commented, "I don't like the meals here." Other peoples' comments included, "I don't like spaghetti hoops", "I don't like the food, I'm used to better quality" and "I haven't had breakfast, I'm not keen on the food." One relative told us, "I'm sure they made up a soup from the left over vegetables from the Sunday lunch, it looked awful." Another relative said, "One of their regular meals is hot dogs, and these can be left in front of residents for up to two hours." Another relative commented, "There is no choice of drinks." Other relatives' comments included, "Sometimes people don't get what's on the menu. It was egg and chips instead of fish", "There's very little fruit" and "There is no choice of food, it's just whatever is there, it's lucky [Name] isn't too fussy."

Menus showed people did not receive a balanced and varied diet. For example, corned beef pie and corned beef hash was the main meal at least three times in one week, mince and sausages were also served several times some weeks. Some relatives told us people's special diets and any cultural or vegetarian preferences were not always catered for. One relative commented, "There is no choice of food for [Name]. I queried why [Name] couldn't have a finger buffet like the other residents." Another relative told us, "They gave [Name] a

potato croquet, mashed potato and mashed peas for their lunch, they still aren't managing to give [Name] a proper vegetarian meal." Another relative said, "[Name] has a soft diet, they were given pasta with raw peppers at lunch, when I arrived later they still had the peppers in their mouth." After the inspection we discussed with the registered manager about obtaining people's feedback about the menus and the times of meals to check it was suitable for all people. We received information after the inspection to inform us that menus were being reviewed.

We recommend that the home follows best practice guidance for the nutritional content of menus and that menus and menu suggestions are reviewed with people who use the service.

People who were at risk of poor nutrition were monitored to check for weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with reduced appetites were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. People's care records included nutrition care plans. Information was also available with regard to any support required to help them to eat.

We observed the lunch time meals in the dining areas. We considered some improvements were required. The atmosphere on the top floor was noisy and not calm and relaxing. Tranquil music was not available to entertain people as they waited or to encourage people to eat their meal. On two of the units staff were particularly busy as people ate their meals in lounge areas, bedrooms and corridors. Staff assisted people who needed full assistance to eat. However, people in some areas were not supervised or encouraged and prompted to ensure they ate their meals as staff were busy in other areas. A choice of main meal was available at each meal. People were also offered protective aprons. Written menus did not advertise the current meal choice to keep people informed and pictorial menus or photographs were not available for people who may no longer recognise the written word. The registered manager told us that this would be addressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 24 DoLS applications had been authorised by the relevant local authority.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used. For example, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best

interests." We saw records for one person which referred to the use of covert medicine. The record did not reflect how the decision had been made as there was no evidence to show that a best interest meeting had taken place with all the relevant people. A medicines care plan was not available to show why covert medicine was required or detailing guidance for staff of how the medicine was to be given covertly.

We recommend the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements, finances, safety and other aspects of their daily lives.

People were supported to access community health services to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, dietician and the speech and language therapy team (SALT).

Staff told us communication was effective to keep them up to date with people's changing needs. One staff member told us, "There is a handover from day staff to night staff and we're kept up to date." Another staff member commented, "We have a handover in the morning when you come on duty." A third staff member said, "Communication is good, we work as a team." A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person.

Requires Improvement

Our findings

People's privacy and dignity were not always respected. We observed that most people looked clean, tidy and well-presented. However, some relatives commented this was not always the case. A relative commented, "I found [Name] heavily soiled and covered in breakfast at 11:40." Another relative told us, "I came in and found [Name] in their pyjamas in the dining room in the afternoon and they were soiled." A third relative said, "[Name] is unshaved most days." Other relative's comments included, "One evening there were only males on duty, no females. [Name] doesn't like personal care from males, and I'm certainly not happy with two male carers looking after [Name]", and "It's quite distressing to see other people in [Name]'s clothes, I feel I don't want them back." People's daily accountability records did show that staff were providing care to people. However, due to staffing levels and people's needs we observed people's personal care and support needs were not always attended to in a timely way as staff were busy.

Most people gave positive feedback about the support they received and the caring nature of the staff. One person said, "I'm quite happy living here." Another person commented, "I can't fault them, staff." A third person said, "Staff will help me when I need it, but I'm a very independent person." One relative told us, "The girls are very nice, they are wonderful people." Other relatives comments included, "I'm very happy with [Name]'s care", "I think the staff understand [Name]", "[Name] is generally well-looked after", "The care staff are gentle and kind when they assist [Name] to eat." Other comments included, "This unit is a nice, kind community. Staff are definitely kind and caring."

On the first floor on the first day of inspection the environment was chaotic and noisy on the top floor. This was not apparent on the second day when it was calm and tranquil. In all parts of the home the atmosphere was friendly and welcoming. One visiting professional told us, "Residents and staff are all very friendly."

We observed when staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and sympathetic manner. Support workers were observed to be caring and patient.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed, when to go out and what they might like to do. We heard staff ask people for permission before supporting them, for example with personal care or offering them protective clothing at the lunch time meal.

Care plans provided information about how some people verbally communicated. For example, one care

plan stated, '[Name] can communicate verbally.' Another care plan recorded, '[Name] understands.' However, care plans did not inform staff how a person communicated if they were in pain or showing signs of distress if they were unable to communicate this information verbally. The registered manager told us that this would be addressed. Staff told us they observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. We spoke with a visiting advocate who was making an introductory visit to the home to support a person. Advocates can represent the views for people who are not able to express their wishes.

People's records were held confidentially and securely on an electronic system. Staff had access to this system to read about people's care and support needs and to complete their records.

Requires Improvement

Our findings

Records showed pre-admission information had been provided by people, their relatives and health and social care professionals who were involved in the persons' placement. Care plans were developed that outlined how people's needs were to be met. For example, with regard to nutrition, personal safety, finances, personal care and communication needs. However, they were not in place for some specific mental health needs to ensure all staff knew how to support the person.

Care plans were in place that provided some details for staff about how the person's care needs were to be met. However, care plans did not detail what the person could do themselves to remain involved and to maintain some independence. Although care plans contained some information, they did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. Another care plan for personal hygiene which stated the person became distressed did not document what staff needed to do to de-escalate the situation when a person became agitated because of personal care interventions.

Detailed information was not available about the social care needs of people such as their interests and aspirations and social care plans. Their records contained limited information about people's history, likes, dislikes and preferred routines. A 'This is Me' profile was not in place for all people with information collected with the person and their family to give details about the person's preferences, interests and previous lifestyle when they were no longer able to communicate this information.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. However, information was not available with regard to people's spiritual and cultural preferences at this important time and for their wishes after death to ensure their final wishes could be met.

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

Records showed that reviews of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. This included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

We observed on the top floor unit there was limited engagement with people as staff were busy. People sat in chairs at the dining table from breakfast time and did not move all day. We saw most people sat sleeping as there was nothing of interest to keep them engaged and stimulated. The only staff interaction with some people was at mealtimes, when the drinks trolley came around or when people were assisted with personal care. Apart from the person who received 1:1 care staff did not take the opportunity to talk to people and spend time listening to what they had to say. We observed around the home people remained in their bedrooms, without stimulation, and staff did not spend time with them except when they took meals and carried out tasks with them. From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person.

An activities coordinator was employed and people told us they had the opportunity to go out on some trips when the weather was fine. However, we did not see any organised activities being carried out individually or in a group with people on either day of inspection as the activities person was working in their other role as a support worker. Sensory and tactile equipment was not available. Rummage boxes and items for reminiscence were also not available for people who lived with dementia. In the afternoon on the top floor unit we observed some people colouring in. In other areas people were colouring in and three people were making coconut ice. One staff member told us, "We don't have time for doing activities with people. If we do we'll do puzzles and play dominoes." A person commented, "There are hardly any activities going on." We observed there was an escalation in noise and distressed behaviour with some people as they sat without occupation, stimulation or distraction.

We recommend that staff receive training about person centred care and personhood to ensure that people who live with dementia are kept engaged and stimulated and offered meaningful activities if they wish to take part. After the inspection we were informed this training was being planned for staff.

People knew how to complain. Some people were uncomplimentary about the home and not all people told us their concerns were addressed. One relative told us, "We get no feedback when we make complaints, we are told it will be dealt with but nothing happens." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place. We saw a complaints investigation would be carried out but there was no evidence of a written response to the complainant to show any action taken if required. We discussed this with the registered manager and we were told it would be addressed.

Requires Improvement

Our findings

The home had a registered manager who had become registered as manager for Ashwood Court in May 2017. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

We had concerns audits were not all effective and carried out within a regular timescale to ensure the well-being at all times of people who used the service.

Some auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included monthly and quarterly audits. Monthly audits included checks on care documentation, falls, nutrition, pressure damage, dining experience audit, infection control, housekeeping, kitchen audit, health and safety and maintenance. We did not see evidence of a medicines audit. Audits were not signed to show who had carried them out. We considered more frequent audits should take place for falls, incidents and the environment in order to identify where more urgent action was required. Audits did not show the action that had been taken as a result of previous audits to ensure people's safety. The audit and governance processes had failed to identify deficits in record keeping, staffing levels, staff training, the environment, quality of food and people's dining experience.

The registered manager told us they received support from the provider. However, there was no system for local support. The provider told us their office was located out of area, approximately three hundred miles away. The registered manager told us they had some contact with them, ensuring there was communication about the running of the home.

A formal external quality assurance system was not in place to ensure external scrutiny by the provider or their representative with regard to the running of the home to ensure it was meeting its aims and objectives to provide quality care. Therefore the quality assurance system did not include evidence of visits by the provider or their representative although we were told by the registered manager visits did take place and feedback was verbal.

Other quality assurance processes included a weekly operating report that included marketing, staffing issues, safeguarding referrals and complaints. This was completed by the registered manager and submitted to head office. However it did not include areas of care provision such as infection control, pressure area care, nutrition, accidents and incidents and serious changes in a person's health status for external monitoring and analysis.

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

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was open to working with us in a co-operative and transparent way.

We received mixed comments from people and relatives about the management of the home. Positive comments included, "I think the manager and staff are on the ball, I don't have to remind them of anything", "The manager does their best", "The home is improving" and "The registered manager is very supportive." Not all people and relatives said they were listened to. One relative told us, "The manager is approachable, but doesn't do anything." Some people who had complained or raised issues at meetings did not think changes were made after they complained. This was discussed with the registered manager to ensure people were consulted and listened to. For example, to advertise the results of the surveys showing action that was taken and what was planned, to provide a written response to complaints to show where action was taken. Also to offer more regular meetings with relatives and people who use the service and to improve consultation with people with regard to the running of the home. For example, activities, outings and menus.

Not all people and their relatives told us they were kept involved and consulted about the running of the service. Some meetings took place with people who used the service and relatives but they were not held regularly. One relative commented, "I think there have only been two meetings." Another relative said, "Meetings don't happen very often." We discussed this with the registered manager.

We considered staff required more direction and leadership in their role so they were aware of the designated tasks each day with regard to the daily routine and to ensure people received effective and responsive care.

Staff were positive about the management of the home. They said they could approach the registered manager to discuss any issues. Staff members told us the registered manager was approachable and had an 'open door policy.' One staff member said, "The registered manager is really approachable." Another staff member told us, "I think the manager is very good, things are improving in the home." Feedback from a member of staff in a provider survey stated, 'The manager has a pleasant and welcoming demeanour.' Several staff members told us they had worked at the home for several years. Most staff were positive about other staff in the home and had respect for them. One staff member commented, "We all work as part of a team."

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings. Meeting minutes highlighted positive feedback from staff and relatives about the service, positive welcoming atmosphere in the home, improvements in staff morale and several other improvements that were being made. However, meeting minutes did not show that all required actions were taken in a timely way. For example, meeting minutes from September 2017 referred to the broken medicine cabinet and highlighted staff training which still had not been addressed at the time of our inspection.

The registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out to relatives and people who used the service, staff and visiting professionals. Areas surveyed included the physical environment,

health and well-being, daily life and customer care. There was positive feedback from people who had completed the feedback forms however they were not dated. Comments included, 'Décor improved in last couple of months', 'All staff are fantastic', 'Everyone is very welcoming', 'Staff are very helpful', 'I do think improvements are needed with food' and 'The home has improved.'

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not all receive person-centred care. Regulation 9(1)(a)(b)(c) 3(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Systems were not all in place to ensure people received safe care and support. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe, effective and person centred care to people at all times. Regulation 18 (1)(2)(a)(c)