Mrs Manny Wragg

Ashlands Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 April 2016 and was unannounced.

Ashlands Care Home provides accommodation and personal care for up to 30 older people including people living with dementia. At the time of our inspection there were 27 people living at the service.

A registered manager is required at Ashlands Care Home. 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. At the time of our inspection there was not a registered manager in place. The provider had newly recruited a manager who was having recruitment checks completed. The provider told us that the manager was due to commence their role imminently and they would submit their registered manager application when in post. We will monitor this.

People told us that they had some concerns about the cleanliness of the service. We found that the systems in place to maintain cleanliness and hygiene were insufficient. The provider had failed to implement requirements made by the clinical commissioning group infection control audit that was completed in November 2015.

Staff were aware of the provider's safeguarding policies and procedures and their role and responsibilities in keeping people safe. The provider was working with the local authority in investigating some current safeguarding concerns.

Risks to people had not always been assessed appropriately, and the control measures identified to reduce risks had not always been put in place. Risk plans lacked detailed information for staff. Accident and incidents were not always recorded appropriately, and there was a lack of analysis to consider patterns, trends and lessons learned to reduce further reoccurrence.

Concerns were identified with the deployment of staff, they lacked direction and organisation. Appropriate dependency assessments to determine staffing levels were not in place. The provider had not always completed recruitment checks before staff commenced employment.

People received their medicines as prescribed but staff did not have information about managing people's medicine prescribed as and when required. People's preferences of how they liked to take their medicines were not recorded.

Some shortfalls were identified with the staff induction, training and support opportunities available to staff.

Staff had limited understanding of the principles of The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. Where people lacked mental capacity to make specific decisions about their care and treatment, some assessment's and best interest decisions had been made but some people's capacity required further assessments.

People received sufficient to eat and drink and choices were offered. Where food supplements had been prescribed, people had received these. People said they liked the food but found the portion size a concern. People did not always receive appropriate support from staff with their eating. External health professionals were involved in meeting people's health care needs. People's care records did not always show what action had been taken to support people's health needs.

Staff communication and interaction with people was variable. People described staff as caring and kind. People did not have available information about independent advocacy services should they have required this support. Information about the complaints procedure was not displayed easily for people to see and was not in an appropriate format for people with communication needs.

Staff had limited information available about people's individual needs, routines and preferences this impacted on their ability to provide effective and responsive care. New care records were being introduced. People received limited opportunities to participate in activities and these did not always reflect people's preferences and interests.

The quality assurance systems in place to monitor quality and safety had not been completed consistently within the service. The provider visited the service regularly but had not recorded the audits they completed to check on quality and safety. These shortfalls had impacted on the development of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not implemented appropriate systems to maintain appropriate standards of cleanliness and hygiene.

Staff were aware of their role and responsibilities about safeguarding people.

Risks to people's needs had not been appropriately assessed and planned for. Risks to the environment were not consistently checked. Accidents and incidents were not robustly investigated or analysed to reduce further risks from reoccurring.

People received their prescribed medicines but some information was missing about the use of medicines that were prescribed as and when required. Also people's preferences of how they took their medicines were not recorded.

People were supported by an appropriate number of staff to keep them safe but concerns were identified with the deployment of staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff induction, training and support required improvements to ensure staff maintained their skills and competency.

People's records showed how the principles of the MCA had been adhered to when a decision had been made for them. DoLS processes had been appropriately applied; however staff knowledge of these safeguards were limited.

People received sufficient to eat and drink and a choice of meals were provided. People did not always receive effective support with their eating and drinking. Monitoring of people's food and fluid was not always effectively managed.

Information about people's healthcare needs lacked detail in places and the monitoring of people's health needs were not

consistently recorded.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were positive about the approach of staff that they described as caring and kind.

The quality of staff interaction and communication with people was variable.

People's privacy, dignity and respect were not always maintained. Staff interaction at times with people was more task-led than person centred.

People did not have access to independent advocacy information.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The quality and quantity of information available for staff to provide an effective and responsive service was limited. People were not always supported with their preferences and routines.

Daily activities were available but these were limited and did not always meet people's interests and preferences.

The provider had a complaints policy and procedure but not all complaints had been recorded or acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The lack of leadership of the service had impacted on quality and safety.

The provider's systems for monitoring the service including internal audits and checks were inconsistent and ineffective.

People, relatives and representatives received opportunities to share their experience of the service if they wished.

The provider had informed CQC of events affecting the service appropriately.

Ashlands 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 21 April 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service including the last inspection report and notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service to obtain their views about the care provided by the service. Prior to the inspection we received some information of concern about the care provided to people and we used this information to assist our planning.

During the inspection we spoke with five people who used the service and four visiting relatives for their experience of the service. Some of the people who used the service had difficulty communicating with us as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the provider, acting deputy manager, a cook who was also a team leader, a senior staff member and two care staff. We looked at the relevant parts of the care records of four people, staff files and other records relating to the management of the home.

After the inspection we spoke with a healthcare professional and the local authority safeguarding team.

Requires Improvement

Is the service safe?

Our findings

People were not always cared for in a clean and hygienic environment and suitable arrangements were not in place to prevent the spread of infection. People who used the service and visiting relatives told us that they felt the cleanliness and hygiene of the service was a concern. One visiting relative told us, "It's ok, not as clean as it could be. The table there (indicated the occasional table in her family member's room) is sticky, they [staff] don't always wipe it and the toilet isn't always clean." Another person said, "It could be a bit tidier I think. On the floor you'll find food and stuff but it's a job keeping it clean I suppose. They [staff] sometimes could keep these (indicated an occasional table being used by his family member) a bit cleaner."

Staff told us that they felt the cleanliness of the service could be improved upon. One staff member said, "There is only one domestic, they try their best." Another said, "I know it could be cleaner but we don't have time to clean and care for people."

We found poor cleanliness and hygiene throughout the home. Both dining tables and individual tables in the lounge were dirty on the surface, underneath and legs. Seating in the lounges were found to be dirty and stained, with encrusted food. Wheelchairs and walking frames were also dirty. People's bedrooms were found to be dusty and rubbish was found underneath beds that appeared to have been there a substantial amount of time. We showed the deputy manager what we found who agreed that the cleanliness of the service was poor.

We were aware that the local clinical commissioning group visited the service in November 2015 and completed an infection control audit. A number of recommendations were made to improve cleanliness, hygiene and infection control prevention measures. The provider was required to develop an action plan to confirm what action they would take to make improvements. On the day of our inspection the provider was unable to find this action plan or the audit report. They told us that the manager who had developed the action plan had since left the service and they were unsure where it was.

We asked the deputy manager what cleaning systems and processes were in place. They told us that there was one domestic that worked six days a week. We saw there were daily records that showed what cleaning had been completed. These records did not include deep cleaning of the service or of equipment. The deputy manager told us that night staff had this responsibility. They showed us additional cleaning records however, these had not been completed since October 2015. The provider could not give an explanation for the reason why night staff were no longer doing any cleaning. This meant that there were insufficient cleaning systems in place to ensure the service was appropriately and adequately maintained.

We observed a staff member handing out individual biscuits to people without using gloves. At one point we saw them carry a biscuit in their hand across the room for a person. This practice demonstrated there were risks associated to cross contamination to people who used the service.

These examples show that the provider had failed to take appropriate and robust action to ensure the cleanliness and hygiene of the service was maintained, and people were not protected from associated

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

People raised some concerns about how some people's behaviour impacted on others. One person said that sometimes the behaviour of others upset and frightened them. Another example was given how people's freedom to use all the communal rooms available was restricted at times by another person who saw it as their space only. We discussed what we were told with the provider who said they were aware of these concerns and that staff provided appropriate support.

Staff were aware of the signs of abuse and told us they would report any concerns to their immediate senior on duty and would escalate through the management structure if necessary. One staff member said, "We've had safeguarding training. Staff are here to protect and care for the residents, their safety is everything." Staff also showed an understanding of the external agencies to contact to report safeguarding concerns, such as the CQC, the local authority responsible for investigating safeguarding incidents and the police. Information was available to staff about the local multi-agency safeguarding procedure for reporting safeguarding concerns and had attended safeguarding adults training.

We were aware that the provider was working with the local authority safeguarding team to investigate some safeguarding allegations. The provider said that they had identified some shortfalls and areas that needed to be improved upon to protect people. This included improved documentation, recording and reporting when concerns were identified.

We asked people if they felt risks to them and the environment were appropriately assessed and managed. A visiting relative told us, "My family member is safe, yes. They can stand a little bit but sometimes they try when there's no-one about. They've never had any falls." Another relative told us, "When [family member] gets up they [staff] are great. They have a pressure mat so they [staff] know and can go to them straight away."

Feedback from healthcare professionals raised concerns that staff had not always taken appropriate action when incidents occurred. An example was given of when a person had fallen and injured themselves, there was a delay in staff contacting the appropriate emergency services.

Staff told us what they did to ensure known risks were reduced and managed. One staff member said, "We make sure the environment is safe, that equipment and obstacles are not in people's way." Another person told us, "Some people need equipment such as pressure relieving cushions and repositioning to protect their skin."

We saw that one person sitting in the lounge had a pressure pad in their seat which made staff aware as soon as they stood up. Throughout our inspection we observed the kitchen door that led off from the lounge was frequently left open. This was despite the kitchen door having a clear notice to staff to advise the door must be kept closed. Most people were living with dementia which meant there was a risk that they could become disorientated and may have entered the kitchen putting them at risk.

There were no Personal Emergency Evacuation Plans [PEEPs] in place for responding to emergencies and untoward events. PEEPs contain information that support staff and emergency services in knowing what support a person will need to be safely evacuated from their home. This meant the service was unable to support people safely in the event of an emergency.

Individual risk assessments had been completed to assess people's risk such as falls, developing pressure

ulcers, nutritional risk, and moving and handling. These contained some information about how the person was affected and the control measures to reduce the risk. We looked at the recording of accidents and incidents and noted there was a high number recorded, but there was no analysis for themes and patterns to reduce further reoccurrence.

Some people raised concerns about staffing levels and the turnover of staff. One visiting relative said, "I think they [staff] get by and nobody suffers except staff themselves, they are pushed."

A member of staff told us, "People are safe but have high dependency needs, we think we need more staff." The provider showed us the dependency tool they used to assess people's needs. We noted that this did not fully consider people's needs and discussed this with the provider. They told us that they would use a different tool to assess people's dependency needs. The provider said that they felt there were sufficient staff available but there was an issue with the deployment of staff that they were going to address.

We observed call bells were answered promptly by staff. By talking to staff and through observation we concluded there were sufficient staff available to meet people's needs. However, staff lacked clear structure, organisation and were not clear about their role and responsibilities, indicating that the deployment of staff was an issue.

We checked recruitment files of four staff members. Each file contained references, proof of identity and the relevant health checks for each member of staff. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people. In two of the records we saw staff members had started working at the service a few weeks before their DBS had cleared. The provider could not confirm if these new staff were lone working or shadowing experienced staff. This meant people's safety may have been at risk by receiving support from inappropriate staff. The provider assured us that safer recruitment processes would be applied in the future.

People told us that their medicines were managed well and raised no concerns. One person said, "I have tablets in a morning and liquid at night. I get them from the staff the same time every day."

We observed medicines administration and found medicines were administered by checking against the medicines administration record and staff stayed with people until they had taken their medicines. We saw how the staff member administering a person's medicine explained what the medicine was for.

Medicines Administration records (MAR) contained a picture of the person and there was information about allergies but no information about the way the person liked to take their medicines. MARs confirmed people received their medicines as prescribed.

We saw the MAR for one person indicated they were given their medicines covertly. This usually involves disguising medicine by administering it in food and drink. As a result, the person is unknowingly taking their medicine. There was a mental capacity assessment and best interest decision for this and agreement from the GP. However, there was no information to show the involvement of a pharmacist to ensure the effectiveness of the medicines were not compromised when administering covertly.

PRN protocols were not in place to provide information on the reasons for administration of medicines which had been prescribed to be given only as required. This is important to ensure staff administer medicines safely and people are not over medicated. Medicines were stored safely in line with requirements in locked trolleys or cupboards. Temperatures were recorded of the areas in which medicines were stored

and were within acceptable limits. Staff administering medicines told us and we saw documentation that they had had competency checks for medicines administration. They also told us they had completed training in medicines administration.

Requires Improvement

Is the service effective?

Our findings

People who used the service and visiting relatives told us that they felt staff were knowledgeable about their needs. One person said, "The staff know how I feel."

A visiting healthcare professional told us that they found staff were often not able to answer questions about people's healthcare needs often saying they did not know the answer to the question they were being asked due to being on leave.

Staff spoken with told us about their induction and said this included shadowing more experienced staff before providing care and support independently. Staff also told us about training that they had completed during 2015 and 2016. This included moving and handling, fire safety, catheter care, pressure care and safeguarding. Staff said that they had received opportunities every three months to discuss their work, training and development needs with their line manager. A healthcare professional confirmed that they had provided staff with training which had been welcomed by staff.

We noted that the staff induction was minimal and provided limited information, training and support for new staff. There were no competency checks as part of new staff member's probationary period. Annual appraisals were not being carried out to review staffs performance and development needs.

Staff told us that they used handover meetings that were both written and verbal to exchange information. We observed a staff handover where each person's needs were discussed, this enabled staff coming on duty to be aware of people's health and well-being needs.

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

We saw some examples where people lacked mental capacity to consent to their care and treatment, assessments and best interest decisions had been made appropriately. However, we also saw where there should have been assessments for people these had not been completed. Staff showed limited understanding of the principles of MCA but did say they had received training. We discussed what we found with regard to MCA with the provider. They assured us that they would, as a matter of priority; assess any person where there were concerns about their mental capacity to consent to specific decisions about their care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider had correctly made an application to the supervisory body where concerns had been identified about this person's freedom and liberty.

We found care records did not show where people had capacity to consent to their care and treatment or if another person had legal authority to give consent that this had been given.

A visiting health care professional told us that they had concerns about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation. This information was not always located easily. We were aware that the provider was implementing new care files and found information was difficult and confusing to find. This was a concern because people's end of life wishes may not be respected due to poor record keeping.

Some people living with dementia had periods of high anxiety which affected their mood and behaviour at times. We saw behavioural incidents were recorded to help establish any triggers and patterns. However, we found that these were not reviewed or monitored. One person's care records showed they displayed frequent behaviours, we found that staff were provided with very limited information about how to support this person at times of heightened anxiety. No behavioural strategies were available to support staff. This told us that people's needs were not effectively assessed or managed.

People and visiting relatives told us that they had a choice of what to eat and spoke positively about the quality of food, but a reoccurring theme was that the portion size was too large. One person said, "I ask them [staff] to cut it down but they still bring me too much on the plate. I feel guilty not eating it but I can't. It's always very nice and it's always hot." A visiting relative told us, "The meals are very good, a good variety." People told us that they had sufficient to drink and we saw drinks were provided throughout the day. We also noted that cold drinks and snacks were on a table for people to help themselves too.

Visiting relatives raised concerns about the assistance people received from staff to eat their meals. One relative said, "I come and feed [family member] as often as I can. I find they [staff] have to dodge between them, give [family member] a couple of forkfuls and then go to someone else so it's practically cold when their getting it."

We observed the lunch time experience for people. We saw that staff provided assistance such as cutting people's food up where required. We saw that not everyone received the support they required. For example, we saw a person was served their meal at an occasional table in the lounge. We saw that the person did not immediately eat but eventually did take a small forkful. We saw that staff walked past this person with no acknowledgement or interaction. Seven minutes after the person was given their meal, a staff member went to them and asked they had finished. We saw the staff member made no attempt at that stage to encourage the person to eat more. We saw that the staff member got the person a fresh cup of tea and then left them again. Twenty minutes from when the person received their meal a staff member returned and sat with them and encouraged them to eat. However, we noted that the person did not eat any more and the delay and the temperature of the food may have contributed to this.

Staff we spoke with showed an understanding of people's nutritional needs and preferences. Specific dietary and nutritional needs in relation to people's healthcare needs or cultural or religious needs were assessed and included in people's plans of care. These needs were known by staff including kitchen staff.

We found food stocks were appropriate for people's individual needs. Where people had been prescribed food supplements these were available and records confirmed people had received these.

Nutritional risk assessments and care plans were in place to ensure people received appropriate food and drink to meet their needs. Food and fluid intake charts were in place and people's intake recorded and weights taken. However, staff were not clear who had responsibility for monitoring these to enable action to be taken if concerns were identified. We found these records were not fully completed; it was therefore

difficult to be certain people had been supported appropriately.

People we spoke with and visiting relatives did not raise any concerns about health care needs being met. One relative said, "[Family member] wasn't very well a few weeks ago, they [staff] thought he might have had a heart attack. They got an ambulance and rang us straight away, they are very good at that." They added, "[Family member] has still got their original GP and they have a district nurse come in if asked."

Staff were aware of people's healthcare needs but some staff were more knowledgeable than others. Staff told us they were supported by a visiting community nurse that supported the service. We saw from care records that this nurse regularly visited the service and reviewed people's healthcare needs. Records showed that where concerns had been identified action had been taken such as referrals to a dietician and the community falls team. However, it was noted from care records that it was the visiting community nurse that had made these referrals; it was therefore difficult to know if staff would have taken appropriate action in the absence of this support. Additionally, we saw that the GP, district nurse and dementia outreach nurse visited people.

Requires Improvement

Is the service caring?

Our findings

All people we spoke with including visiting relatives spoke positively about the care and approach of staff. One person said "They [staff] are very caring, they seem so kind. They treat me with respect. You just feel at home, at ease. They are there whenever you need them." A relative told us, "I'm really pleased with the care [family member] has had. Staff are very attentive and caring." Another relative said, "The care [family member] gets is great and we can't fault it. I can go away on holiday and be confident they'll [staff] deal with everything appropriately."

Staff demonstrated an understanding of people's routines and preferences. People were seen to be relaxed and comfortable in the presence of staff. People were supported to develop friendships. One person said, "I always sit with the same people and I enjoy it. I look forward to it." We saw some people chatted over lunch, showing jewellery, laughing and staff involved others around their table in conversations.

We saw some good communication by staff when talking with people, this included talking with people at the same eye level, using clear language and giving people time to respond. However, we also observed poor communication at times from staff. For example, a member of staff asked two people separately what they wanted for their lunch. Both people appeared confused and the staff member gave no encouragement or support in making a choice, and they walked away without determining what either person wanted. Their manner was short, impatient and dismissive. We also noted that staff often talked loudly to people from across the room instead of talking with people face to face in a more polite, respectful and caring way.

Observations of staff's approach in supporting and interacting with people were found to be inconsistent in terms of the quality of care provided. We saw one member of staff in the lounge just before lunch was being prepared. The staff member's interaction with people was good and they were seen to explain and reassure people about what was happening. One person was offered a neck support pillow when being assisted with their meal to make them more comfortable.

We saw a member of staff give a person their medicines in a pot. They then stood and chatted with the person, complimenting them on their hair, whilst ensuring the medicine was taken. We saw the staff member did all this in a kind, reassuring and patient manner and that they thanked the person as they gave the pot back.

We saw two staff helping a person to transfer from an easy chair to a wheelchair. We saw that they explained what they were doing and what they wanted the person to do. They did this in a kind, gentle and reassuring manner.

However, we saw two different staff hoisting a person in a chair to re-position them. We saw that although they did ask the person if they were, "ok" they gave little explanation or reassurance. The task was conducted to a larger degree in silence or with the staff talking to each other. The staff did not appear to be as gentle or considerate as they perhaps could have been.

We saw another member of staff supporting two people to the dining room. They were holding one person by the arm and encouraging the other to follow them. Both people were using walking sticks. The staff member was "dancing" to the music as they walked and it was clear they were walking too fast for the person following and this was causing them some distress.

Whilst relatives said that they felt included in discussions and decisions, there was no formal opportunities for people to express their views and wishes about the care and support they received.

No information was available to people and their relatives about local independent advocacy services. Independent advocates represent people's wishes and what is in their best interest without giving their personal opinion and without representing the views of the service, NHS or the local authority.

Some concerns were expressed about how people's dignity, privacy and respect were met. A relative raised some concerns about how their family member was sometimes presented. They told us, "They [family member] spilled a cup of tea on themselves the other day and they were wet. Staff said, 'We won't change them now. We'll wait 'til we toilet them.' I don't think they change them quick enough." They added, "It might be better if there were wet wipes." We later saw this relative ask a member of staff if they could have a wet wipe whilst they were assisting their family member to eat. We saw a staff member brought a pack and said, "pull one out" and then took the pack away. We saw that none of the three people eating at tables in the lounge had napkins or wipes. We also observed a person asking for a tissue, there were no staff around and a member of the inspection team requested tissues from a member of staff. These were fetched but not left out for people. We also received information of concern prior to our inspection telling us that staff had changed people's catheters in view of other people and visitors.

Staff told us what they did to protect people's privacy and dignity. One staff member told us, "We respect people's choices, give people their personal space and close curtains and doors when providing personal care."

We saw staff took people to private areas to support them with their personal care and saw staff knocked on people's doors before entering. Staff were observed to discretely reposition a person's clothing to protect their dignity.

Requires Improvement

Is the service responsive?

Our findings

One person told us they were satisfied with the support they received and felt their preferences and routines were respected. They said, "I can wash and dress myself, always have. I get up myself but they [staff] look in to see if I'm alright. I can decide for myself when to go to bed. They come up with me, draw my curtains for me and pull the bed back and check I'm ok before leaving me." Three people said that their preferences and routines were not always respected. A visiting relative told us, "Sometimes [family member] has said that they wished staff would come and get them up sooner; that they wait too long." Another person said, "I get up when they [staff] tell me." An additional person said, "I like to have a wash before I have breakfast but that doesn't suit them [staff]. This morning I had breakfast first. It's not the end of the world but it's my preference."

Visiting relatives told us that they were aware that their family member had care records that informed staff of what their needs were. One visiting relative said, "I've seen one (care plan) quite a while ago, maybe last year so [family member] has got one. You can always pop into the office or talk to the senior people and they answer any queries." Another visiting relative told us, "Yes I've seen it (care records) and I'm always looking at it, say when [family member] was losing weight and in reviews." We received information of concern prior to our inspection telling us that staff had completed care records stating what personal care had been provided when it had not. For example, we were told staff had recorded a person had received a wet shave, but this person's relative visited the same day and found their family member unshaven.

Staff told us that people's care records were in the process of being transferred to new documentation and they were hopeful that this would be an improvement. They said that the old style records used were confusing and not easy to use.

We found information in people's care files about their preferences, routines and personal history lacked detail. Most people living at Ashlands Care Home were living with dementia and they had difficulties with memory and communication. It was therefore important for staff to have this detailed information available to support people with any anxieties and to engage in meaningful conversations.

People who used the service and visiting relatives raised some concerns about the lack of activities and social opportunities. Comments received stated that opportunities to pursue interests, hobbies and pastimes were limited. One person said, "I'm afraid I don't do much. I do knitting and I read a lot. Occasionally we have a singer in and a lady who does exercises and she's good." Another person told us, "I'd like to go to a garden centre, sit on the banks at Rufford Abbey, and have a cup of tea and look at the view."

One visiting relative told us, "People used to go out for meals to the pub and [family member] enjoyed that but they stopped when the manager left a few weeks ago." Another visiting relative said, "It would be nice if they [staff] took them out in the garden sometimes but I guess they are busy." An additional relative told us, "People are all sitting there in a circle and there's no motivation, stimulation for them and I think that's so off-putting. It's the first impression you get and I find it really upsetting."

Several people including visiting relatives made comments about the playing of loud music all the time in the lounge. One person told us, "They [staff] want me to go down to the lounge but I don't want to. It's my choice. They don't talk down there; they just have loud music on." A visiting relative said, "The music's a bit loud I think. I don't know if it's for the benefit of staff or residents."

We saw that often music was playing loudly but people who used the service did not demonstrate that they were enjoying it. On occasions we saw that staff were dancing to the music, either on their own or they involved one or two people. A significant number of other people were either not listening or distracted by it. Staff did not always pick up that some people appeared bored or agitated with what was going on.

Staff told us that they tried to provide an activity in the morning and afternoon. At 9.30am we observed a staff member encouraging people to participate in a skittles game. Some people joined in with encouragement but most did not. We were concerned of the timing of this activity because people were still eating their breakfast but had to wait for assistance from staff.

Most people living at Ashlands Care Home were living with dementia. We saw there were few adaptations to help people with orientation around the home. For example on the first floor there was little differentiation between people's bedroom doors and service doors. We saw some, but not all, bedroom doors had signs with a room number and person's name. Some had larger laminated signs as well and some photographs of the person. Corridors had hand rails of a different and contrasting colour to the walls to assist people walking. We saw there was little visual stimulation on corridor walls upstairs but there was an attractive and stimulating mural on the walls downstairs.

We asked relatives for their views on how complaints were managed. One relative told us there were, "No follow up on complaints made and that there were no feedback from meetings." Another relative said they had made a complaint once about cleanliness saying, "We did once, nothing changes." An additional visiting relative told us, "If there's anything we are concerned about we mention it we can easily approach them [staff]." They gave us an example of a visit by an optician that they had concerns about. They said, "I told the manager and they don't use the same optician again, they [staff] do listen."

Staff showed an understanding of the complaints procedure and said if they could resolve minor concerns they would but they would report all concerns and complaints to the home manager or provider.

There was a system in place to receive and handle complaints. Records checked showed that some complaints raised over the past year were responded to appropriately. However, more recent complaints we had been made aware of were not recorded which meant the service was not always being responsive when dealing with serious concerns raised.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us that the change of managers and turnover of staff was a concern to them. A person who used the service told us, "We've got no manager. We've got nobody to complain to if there's anything wrong." One visiting relative said, "They've [service] had quite a few staff coming and going [family member] gets to like them and then they go." Another visiting relative told us, "We think it would be nice if there was some male staff. There's been some but they don't stay long .There's a problem here, they don't seem to stay long, even the female staff and the managers."

A visiting healthcare professional raised concerns with us about the leadership of the service. This included contact and communication with the manager who had recently left and with the provider. They said that they had concerns about the quality of care records stating that important information was often missing. Daily care records were not completed appropriately and pre-assessments did not include all relevant required information.

Whilst we were aware that the provider was in the process of implementing new care records the information available for staff was chaotic, not easy to follow up and lacked in places, specific individual information about people's needs. We found records were not always kept up to date. For example, the frequency staff monitored people's weight did not match what was in people's care records. We found daily records such as food and fluid intake, repositioning and personal care were not being checked to ensure people had received care and support as required. This meant people's needs were not being monitored appropriately to ensure their safety; health and well-being were being met.

Health appointments and tests were not always recorded in people's files. For example, when we asked if a person had been supported to have certain tests that the GP had requested, staff were unable to tell us and care records did not contain this information. The senior had to contact the GP surgery to enquire. Care plans and risk plans were not always sufficiently detailed for staff to provide an effective and responsive service.

The lack of clear leadership meant complaints were not being handled appropriately. For example, a relative told us that they had recently complained that the family member's toilet was not working properly. We found that this had not been recorded anywhere and after checking the toilet found there was still a problem. The staff training matrix had not been kept up to date to show what training staff had received. This meant it was difficult for the provider to review when staff required refresher training to update their knowledge.

The internal systems in place to check on quality and safety were not consistently completed. Whilst the provider told us that they visited the service weekly there were no records of these visits to show they were auditing the service. There were no system in place to monitor accidents and incidents to consider themes and patterns and lessons learnt to reduce the risks of further reoccurrence.

These are examples of a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staff spoken with were positive about working at the service. One staff member said, "We try and make the service feel like home." Another staff member told us, "I'm here for the residents I'm passionate about my job, it could be my mum or dad here." Staff told us that the change of staff and manager was unsettling. They said that they felt they worked well as a team but were aware that improvements were required. This included better communication and improving record keeping. They also said that staff were not all clear about their roles and responsibilities and this impacted on how effective the service was. Staff said that staff meetings were held twice a year but felt this should be more frequent.

Staff were aware of the whistle blowing policy and procedure. A whistle-blower is protected by law to raise any concerns about an incident within the work place. Staff said they would not hesitate to use this policy if required.

During our inspection we were introduced to the newly recruited manager who was visiting the service, and was going through their necessary pre-employment checks. The provider told us the manager was due to start the following week and that they would submit their registered manager's application. The provider had notified us of events that they are required to do.

People, relatives and healthcare professionals had completed surveys to feedback their views about the service. Meetings were also arranged for people who used the service and their relatives. One visiting relative said, "We did fill a form in once to say what we thought but you are always careful of what you say because you don't want to upset them [staff]." Another visiting relative told us they had not completed any questionnaires but as regards meetings said, "Yes they do have them, I do like to come and be included. If I can't I get the agenda and comment."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider must assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good Governance. The provider must establish effective systems or processes to assess, monitor and improve the quality of service. The provider must assess, monitor and mitigate the risks relating to the health, safety and welfare of people use the service. The provider must maintain an accurate and complete record in respect of each person's care and treatment. Regulation 17 (2) (a) (b) (c)