Ashmore House Care Home

Ashmore House

Inspection report

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Ratings

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

Overall summary

This inspection was carried out on 16 and 17 February 2015.

Ashmore House provides accommodation for up to 9 older people who need support with their personal care. The service is a converted domestic property. Accommodation is arranged over two floors. A stair lift is available to assist people to get to the upper floor. The service has 5 single bedrooms and two double rooms, which two people can choose to share. There were 6 people living at the service at the time of our inspection.

The registered provider is a partnership, one of the partners is the registered manager and they were working at the service on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered providers worked at the service almost every day.

We received concerns about the care received by people living at Ashmore House from the local authority safeguarding team and commissioners. We inspected the service to make sure people were receiving safe, responsive and effective care and support.

Summary of findings

The providers did not have a system to ensure the service was provided by sufficient staff with the right skills and experience. Care staff completed domestic and cooking tasks in addition to caring tasks. People had to wait for the care and support they needed. Some people were not able to call staff from their bedroom when they needed support. People were at risk as staff were completing two or more tasks at once, including serving meals and administering medicines. Staff had not completed all the training they needed and people could not be confident that staff had the skills and knowledge to provide their care safely and effectively.

People were at risk of loneliness, isolation and boredom and had very little opportunity to participate in activities and past times they enjoyed. People told us they had nothing to do. The providers had not asked people for their views about the service they received and had not responded to complaints people made. There was no process to review the service and make improvements.

Medicines were not protected from extreme temperatures (hot and cold) and there was a risk that the medicines may not be effective or may harm the person taking them. Guidelines were not in place for 'when required' (PRN), and there was a risk people would not get the medicines, including pain relief they needed.

Effective safeguarding processes were not in place and staff did not know how to report concerns they may have. Evacuation plans did not give staff the guidance they needed to keep people safe in an emergency. People were at risk as the building and equipment had not been maintained. People were unable to have a bath as the bath was broken. Important safety checks had not been completed to ensure that the premises did not pose a risk to people.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Systems were not in place to make sure that people's liberty was not unlawfully restricted.

People were not offered choices about the food they ate. Food was not prepared to meet people's specialist dietary needs and keep everyone healthy. Meals did not include fresh vegetables. People were not offered snacks regularly during the day. People who needed pureed food were not able to taste the flavours of each food as it was pureed together.

Risks to people had been identified and action to keep people safe had not been taken. Changes to the care people need had not been planned. Staff did not always deliver care in the way it was planned or as people preferred.

The staff did not know what the aims and objectives of the service were and were not supported to provide good quality care. Systems were not in place to check the quality and safety of the service and the providers had not identified the shortfalls in the quality of the service and practice we found at the inspection.

Effective systems were not in place for staff to share information about people and the care they needed. Records were kept about the care people received and about the day to day running of the service. Information about people could not be located promptly when it was needed.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

There were not enough staff with the right skills and experience to meet people's needs. Staff did not have time to spend with people.

The building and equipment was not maintained and important checks had not been done. Emergency plans did not support people to remain safe.

Risks to people had not been assessed and action had not been taken to reduce risks to people.

People's medicines were not stored safely. People were not protected from harm and abuse.

Is the service effective?

Inadequate 

The service was not effective.

The provider did not assess people's ability to make decisions. Arrangements were not in place to check if people were at risk of being deprived of their liberty.

Food was not prepared to meet people's specialist dietary needs and to keep people healthy. People did not have a choice about what they ate.

Staff had not received all the training they needed to provide safe and appropriate care to people. People and their relatives were not involved in the planning of their care.

People did not have the support they needed with their health needs.

Is the service caring?

Inadequate 

The service was not caring.

Staff did not always speak to people respectfully. Staff spoke to each other, in front of people, in languages people could not understand.

People and their relatives had not been asked how they preferred their care to be provided.

Staff did not chat to people or provide them with information about the care and support they were providing.

Is the service responsive?

Inadequate 

The service was not responsive.

Staff did not always give care in the way it was planned.

People were at risk of loneliness, isolation and boredom. People had limited contact with staff. People told us they had nothing to do.

Information about how to make a complaint was not available to people in a way that they could easily understand. The registered manager had not responded to complaints people made.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Staff did not know the aims of the service. Care was not provided in the way described in the provider's statement of purpose.

Checks on the quality and safety of the service had not been completed. People, their relatives and staff were not asked about their experiences and views of the care. The providers were not aware of the shortfalls in the quality of the service and staff practice.

Records about the care people received and the management of the service could not be located easily when they were required.

Ashmore House

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 16 and 17 February 2015 and was unannounced. The inspection team consisted of one inspector 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

We did not ask the provider to complete a Provider Information Return (PIR) because we inspected at short notice following some concerns raised with CQC. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before our inspection we looked at all the information we held about the care people received. We looked at previous inspection reports and notifications received by the CQC. Notifications are information we receive from the service when a significant events happened at the service, like a death or a serious injury.

We spoke with the local authority safeguarding manager who was leading the investigations into quality and safeguarding concerns. We looked at all of these areas during our inspection.

During our inspection we spoke with five people, three people's friends and relatives, two staff and both the registered providers. We looked at the care and support that people received. We viewed people's bedrooms, with their permission, we looked at care records and associated risk assessments for four people. We observed medicines being administered and inspected five medicine administration records (MAR). We observed a lunchtime period in the dining room and lounge.

We last inspected the service in April 2014 and found the provider was meeting the requirements of the regulations we looked at.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I like it here, the staff are nice to me" and "Its better living here than being at home where I kept having falls".

Staff knew the signs of abuse, such as bruising or a person being withdrawn and how to report abuse to the provider. Staff did not know how to report suspected abuse to the local authority safeguarding team or the Care Quality Commission (CQC). Staff had not completed safeguarding and whistleblowing training. Guidance and information about the systems the provider had in place to identify and respond to safeguarding concerns was not available to staff. The provider had not put a safeguarding or whistleblowing system in place.

The provider had not taken steps to identify the possibility of abuse and prevent it before it occurred. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that there were not enough staff to provide the service. Another person said, "Sometimes it's hectic and chaos here".

The provider did not have a robust system to help them decide how many staff with the right skills and experience were needed to meet people's needs at all times. They told us that their process was to "ask staff how they are coping". Care staff told us that there were sufficient staff on duty to meet people's basic needs and complete the other tasks required of them. A cleaner was employed for 1 hour each week day. The remaining cleaning, laundry and catering tasks were completed by care staff. The providers worked in the home providing care and support to people every day, they also provided cover for staff sickness, holidays and vacancies. The registered manager did not have any time to complete management tasks as they spent their time supporting people.

The routines of the home were designed around basic care and housekeeping tasks. People did not have a choice about when they got up or went to bed and had limited choices about where they spent their time. The night staff member worked alone and got up and put to bed three people who required the assistance of one staff member. Three people who required the assistance of two staff got up after 8am and went to bed before 8 pm when two staff members were on duty. When staff were assisting these people no staff were available to keep the remaining three people safe. If people required the support of two staff at night in an emergency the providers were on call and would visit the service to support the person. Everyone ate their breakfast in their bedroom and spent the morning in their room whilst staff completed housekeeping and catering tasks.

People had to wait for the support they needed as staff were completing other tasks. On both days of the inspection we observed one person in the dining room received their meal and medicines approximately 15 minutes after another person in the dining room. The person was watching the other person eat and looked concerned and worried. Staff did not tell the person when they would receive their meal.

Staff did not have time to spend with people. People received little interaction from staff whilst they were in their bedrooms and in communal areas. Systems, like call bells, were not in place for people in the lounge, dining room and some bedrooms for people to call staff if they needed them. We heard one person shouting out from their upstairs bedroom for support. Both staff members were downstairs and could not hear the person. We told staff that the person was calling for help.. Staff did not know if the person had a call bell in their room.

There was a risk that sufficient staff would not be available to provide people's care safely and effectively. People's health, safety and welfare was not safeguarded because the registered provider had not taken action to make sure, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed to provide the service. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A fire evacuation plan was in place for each person. The plans were the same for each person and did not provide guidance to staff about how to support each person to safely leave the building in an emergency. Staff said they had not practiced evacuating people from the building and there was a risk that staff would not know what action to take in an emergency. We found that one fire exit was

Is the service safe?

locked and fire safety checks had not been completed regularly. A fire safety check had not been completed for several months. We informed the local Fire and Rescue Service about what we had found.

Not all accidents involving people were recorded. Accident records were not checked to make sure they were accurate and complete. The registered manager told us that one person had sustained injuries to their legs from the footplates of their wheelchair, these had not been recorded. An investigation to find out how the injuries had happened had not been completed. The registered manager had changed the way in which the person's care was provided and a hoist was now used to move them between their bed and their wheelchair. The person was pulled backwards in their wheelchair. The registered manager had not recognised the risk that the person looked anxious or when being moved backwards in their wheelchair.

Reviews of accident records were not completed to identify possible causes or patterns of accidents and when risks to people had changed. One person had fallen often; none of the falls had been seen by staff. A falls risks assessment had not been completed and the person had not been referred to their doctor to explore why they might be falling. The registered manager had failed to assess the person's risk of falling and take action to keep them safe.

Some risk assessments, such as nutritional risk assessments, had been completed. However, these were not all up to date and consistent. The action required to be taken to keep people safe was not clear. We viewed the nutritional risk assessments for two people at risk of losing weight. The registered manager had completed two assessments for one person which showed them as being at medium risk and at high risk. The assessment for the other person had not been reviewed since May 2013. People had not been weighted regularly. Care and support had not been planned to support the person to remain healthy.

Risks to people's skin had been identified and action had been taken to keep people's skin as healthy as possible, including the use of special cushions and mattresses.

The provider had failed to take action identify, assess and manage risks relating to the health, welfare and safety of service users. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks on the environment and equipment had not been completed. The providers knew that the landlord's gas safety certificate for the building had expired but had failed to get a further safety check completed. We told the registered manager a check was required and they booked one whilst we were completing the inspection. Required safety checks of the fire safety system and the hoist had been completed by visiting contractors.

The provider had failed to ensure that people were protected against the risks associated with unsuitable premises, as the premises had not been adequately maintained. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four door bells were fitted to the front door of the building. None of these worked. Visitors to the service, including people's relatives and friends had difficulty gaining access to the building. We had to knock on the door several times and waited for almost 10 minutes before the door was answered. The registered manager had not taken action to make sure that visitors could access the premises without delay.

Some fittings and equipment were damaged and could not be used. The service did not have a working bath and people were unable to bath or shower. One person told us, "I only have a wash-down. I used to have a bath and I liked that but it's broken and I haven't had a bath for about 2 years". The providers had not taken action to make sure that people could bath.

Furniture in people's bedrooms and communal areas was worn and tatty. Some furniture was damaged and people were at risk of cutting themselves. The damage to furniture made it difficult to keep clean and was an infection control risk. The providers did not have maintenance or refurbishment plans in place to make sure that the premises and equipment were safe and met people's needs. A maintenance person was not available to repair and maintain equipment and the premises. The registered manager made minor repairs however the required

Inadequate

Is the service safe?

maintenance of the building and equipment had not been completed. Environmental risk assessments had not been completed, risks and not been identified and action had not been taken to manage risks from the building, furniture and equipment.

The provider had failed to take make suitable arrangements to protect people from the use of unsafe equipment. Equipment was not properly maintained and suitable for its purpose. This was a breach of Regulation16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff giving people their medicines had received training to do this safely however checks to make sure that staff continued to give people's medicines safely had not been completed. Staff gave people their medicines at the same time as completing other jobs such as cooking and serving meals. There was a risk that staff may make mistakes when giving people their medicines as they were distracted.

Some people were prescribed medicines when they needed them (PRN), such as pain relief. Records of when PRN medicines were required or refused were not accurate. Guidelines were not provided to staff about when some PRN medicines should be offered to people. There was a risk that people would not receive their medicines when they needed them.

People's medicines were not stored safely. The providers had not followed recognised guidance when storing medicines. Medicines had not been protected from extreme temperatures (hot and cold) or excessive moisture. There was a risk that all the medicines people were prescribed may not be effective or may harm the person taking them.

. Systems were in place to make sure that regular medicines were ordered on time and returned to the chemist if they were no longer needed. Records were kept of the medicines people received.

People were not protected against the risks associated with the unsafe use and management of medicines because appropriate arrangements for the storing and the safe administration of medicines were not in place. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment systems protected people from staff who were not safe to work in a care service. The registered manager had obtained sufficiently detailed information about staff's previous employment, including an employment history. The conduct of staff in previous employment had been checked. Disclosure and Barring Service (DBS) criminal records checks had been completed for staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Inadequate

Is the service effective?

Our findings

People were offered very little choice about the service they received. There was no choice of food and people were not consulted about what they would like to eat. One person told us, "The food is OK I suppose". Another person told us "It would be nice to sometimes have egg and bacon for breakfast". A third person told us, "lunch was alright".

Meals were not planned and people did not know what they would eat at the next meal. People had not been asked what they liked to eat and had not been involved in planning their meals. Staff told us they cooked what was available in the freezer. Meals only included fresh vegetables at the weekend. No fresh fruit or vegetables were available for people on the days of our inspection. The lunchtime meals did not look appetising and there was little variety in the food offered for lunch each day. Water was provided for people to drink during the day, people had to supply their own squash or fruit juice.

Food was not prepared to meet people's specialist dietary needs. Some people were at risk of losing weight and required additional calories. Food for these people was not fortified with additional calories. Staff did not know which people required fortified foods, and there was a risk that people would not be offered enough calories to support them to stay healthy.

Low sugar foods were not available for people with diabetes. We observed staff offer one person a pancake with sugar and lemon for their pudding. The person requested more sugar several times but was told they could not have any more as they were diabetic and there was lots of lemon on the pancake. Staff had not recognised that the pancake may be tart with lots of lemon and very little sugar. The person was given a second pancake with less lemon and again asked for more sugar. The person became angry and frustrated that their pancake was not sweet enough and they were not given additional sugar. No sugar substitute was available at the service. The previous day the person had eaten an ice-cream for pudding. People did not have a choice of foods that met their needs and supported them to stay healthy.

People who had difficulty swallowing or were at risk of choking were offered pureed food. The lunchtime meal on one day was sausages, potatoes and mixed vegetables. Everything was pureed together and presented in a plastic bowl. People were not able to taste the flavours of each food. There was a risk that people would not eat the food because of the way it was prepared and presented.

People were offered breakfast after 8am. Lunch was offered at 12 noon. People told us that they were not hungry at 12 noon, one person had their lunch at 1 pm at their request. Afternoon tea was provided at approximately 5pm. Snacks were not offered to people between meals or before people went to bed. Action had not been taken to ensure that everyone was offered food and drinks regularly during the day. People were not regular weighed to check that they had not lost weight and were receiving sufficient food.

People were not offered suitable and nutritious food in sufficient quantities to meet the needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff made decisions on people's behalf. Decisions were not made in people's best interests when they lacked capacity to make the decision. People who did have capacity were not offered choices. The registered manager did not have a system to assess people's ability to make specific decisions when they may lack the ability to do so. Some people had appointed relatives or other people to make specific decisions on their behalf when they were unable to do so. The registered manager did not know what decisions people's representatives could lawfully make on their behalf or when they needed to make decisions, with others, in the person's best interests.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was not meeting the requirements of DoLS. Staff were unaware of their responsibilities under DoLS. The providers did not have arrangements in place, as the managing authority, to check if people were at risk of being deprived of their liberty and apply for DoLS authorisations. People were unable to leave the service without the support of staff when they wanted to and were under constant supervision. Applications for DoLS authorisations had not been made by the providers and there was a risk of being unlawfully deprived of their liberty.

The provider did not have a system to assess people's capacity or act, with others, in people's best interests.

Inadequate

Is the service effective?

Systems were not in place to check if people were at risk of being deprived of their liberty. The requirements of DoLS authorisations were not complied with. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When staff had first started to work at the service they received an induction to get know the people and the care and support that they needed. A system was not in place to ensure staff received training to provide care to people safely and to an appropriate standard. Staff had completed basic training including moving and handling and fire safety. Staff had not completed training to enable them to meet people's needs and provide respectful and dignified care, such as equality and diversity training and diabetes training. The registered manager did not have a system to monitor the care staff provided to ensure staff had the skills to provide care safely.

The registered manager did not have a system in place to support staff to provide care safely and to an appropriate standard. Staff did not meet regularly with the registered manager to talk about their role and the people they provided care and support to. The providers did not operate an appraisal process to monitor staff development. Staff said they did not have the opportunity to discuss their role and were not supported to develop. For example, we saw that staff did not treat people with respect. This had not been identified by the providers and staff had not been supported to develop respectful attitudes and behaviours towards people.

The provider had failed to enable staff to deliver care to an appropriate standard as staff had not received appropriate training and support. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care had not been planned to ensure that people did not become unwell. Information was not available to staff to help them identify the signs and symptoms of when person became unwell and the action they needed to take. Staff had not received information about the changes they may see in people with diabetes which would indicate they were unwell.

Some people had behaviours that may impact on other people. Support for people had been planned to keep them and others safe. Staff were not aware of the plans and each staff member had their own way of supporting the person. Consistent care was not provided to keep the person and others safe.

People were not supported to have regular health checks. One person told us, "I haven't had my eyes tested for a long time and I don't think these glasses are much good anymore so I can't really read". Another person told us that they also needed an eye test and needed to see a dentist as their teeth were broken. A chiropodist visited the service every six to eight weeks to provide care to people who wanted to purchase it.

A record was kept of when requests for visits or checks were made to people's doctors. The outcomes of the visits and checks were not consistently recorded in people's records. Changes in the care that people needed were not recorded in people's care plans and there was a risk care would not be provided as prescribed by the doctor or nurse.

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

One person told us, "I like it here, the staff are nice to me". One person's relative said "I come here regularly to visit. It is a nice home and always smells fresh and clean. The staff are very nice". People appeared relaxed in the company of staff.

Staff did not chat to people or provide them with information about the care and support they were providing. People were not told what the lunch was as they were served. There were long gaps between each person being served. Some people had finished their meal before others had been served. Staff did not tell people when their meal would be served. Food was not always served to people in a dignified way. Meals for people on a soft or pureed diet were pureed and mixed together rather than each food separated.

Staff did not speak to people and listen to what they had to say. Where people were unable to speak clearly, staff assumed they knew what people wanted and made decisions on their behalf. People's views were not respected and staff did not take people's views into consideration when providing the service. One person said that they were often disturbed by staff cleaning at night. One staff member told us the person, "is such a pain, they have their own agenda and want things their own way". Night time cleaning had not been planned to prevent the person from being disturbed.

Staff did not treat people with respect. One staff member described a person to us as, "very strange", "very weird" and "unreasonable". One person told us that staff who did not have English as their first language often spoke to each other in their first language in front of them. The person said, "You don't know what they are talking about. It makes me feel left out."

People were not supported to continue to follow their chosen religion. One person used to visit a local church but this had stopped, the registered manager did not know why. Action had not been taken to support the person to continue to practice their beliefs. Another person told us "I wish someone from the Church would come and give me Communion". We spoke to the person's visitor who said they would arrange this for the person.

Staff did not know people well or about their life before they moved into the service. People and their relatives had not all been asked for information about their life history. . When people had given information about their past this had not been used to plan and deliver the care people wanted in the way they wanted it. When people were able to tell staff how they preferred to be helped with their care, staff provided care as people wished, when this fitted in with the routine of the service. There was a risk that people would not have their needs met in the way they preferred.

People's privacy was maintained. Personal, confidential information about people and their care and health needs was kept securely. Staff described to us how they maintained people's privacy when they provided personal care.

The provider had not taken action to make sure that people were treated with respect and had their views taken into consideration. People were not supported to make or participate in making decisions about their care and treatment. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no restriction on people's family and friends visiting the service. People and their relatives told us that they visited often.

Inadequate

Is the service responsive?

Our findings

People told us they had very little opportunity to follow their interests or take part in social activities. Two people we spoke with told us, "There is nothing to do except sit here". Three people spent each afternoon in the lounge with the television on. They told us, "We are not really watching it as it is not interesting". People also said, "I feel I want to do something to pass the time, but there is nothing to do here" and "We are so near the sea here, I would love to go down to the front sometimes".

People were at risk of isolation, loneliness and boredom. People stayed in their rooms for long periods of time and had limited contact with staff. People spent their time either watching the television or doing nothing. One of the providers told us that they 'played' with each person for ten minutes between 1 and 2 pm every day. This was the only social interaction people received other than when they received care. People had not been supported to maintain contacts with the local community. Community groups and entertainers were not invited into the service to meet with people. People's friends and relatives were able to visit when they wanted too.

People we spoke with knew that staff kept records about the care they received. One person said, "They keep notes about me but I have never seen them". Everybody we spoke with accepted what staff did for them. One person said, "The staff are doing the best they can". People and their relatives had not been involved in developing people's care plan and they had not seen them.

People and their representatives were not involved in planning their care. Care had not been planned to meet all the needs people had. One person at risk of losing weight was unable use the services weighing scales. The person's arm was measured approximately every two months. The aim of the measurement was to assess if the person had lost weight. Records showed that the measurement had changed. Instructions were not provided to staff about how and when to measure the persons arm, and what action they should take it the person's arm measurement decreased. Care had not been planned to keep the person well.

Assessments of people's needs had been carried out before they moved into the service. Some further assessments had been completed once people began to receive a service.

Information from assessments was used to develop people's care plans. Care plans included information about what people were able to do for themselves. This information was taken from the assessment rather than speaking with people and asking them what they felt they could do.

The registered manager reviewed people's assessments and care plans approximately every month. People and their relatives were not involved in these reviews. Changes in people's needs had not always been identified and care had not been planned to reflect the changes. Detailed guidance was not consistently provided to staff about how to provide people's care and support. Staff told us that they did not have time to read the care plans and relied on the registered manager and other staff to tell them how care should be provided.

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person we spoke with said they had raised concerns they had about the food and the care and support they received with the registered manager. They said the registered manager had responded that it was all he could afford. The person told us that they did not write their complaints down as they thought the registered manager threw them away. They told us that changes had not been made when they had made complaints. The provider did not have a process to record complaints received and the action they had taken. They told us that no complaints had been received about the service and had not considered the person's comments as a complaint. Information about how to make a complaint was not available to people in a way that they could easily understand.

The provider had failed to bring the complaints system to the attention of people and their relatives in a suitable manner and format. The provider had failed to ensure that complaints were fully investigated and resolved to the person's satisfaction. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

One person told us, "Staff do as well as they can but they don't know how good the care could be".

The providers did not have a clear set of values and behaviours they required from staff, such as compassion and respect. The provider's statement of purpose, which was not available in the service stated its objective was 'to provide care to all services users to a standard of excellence which embraces fundamental principles of good care practice'. The core values of the service were 'Privacy, Dignity, Rights, Choice, Independence, Security, Respect, Equality and Fulfilment'. Staff did not know what the objectives of the service were when we asked them. The providers were not meeting their objectives and had not taken action to ensure staff promoted a culture of independence and involvement of people.

The providers had not identified the concerns about the service people received that we found. Staff had not received information and guidance about how to provide safe and effective care to meet people's individual needs. The providers had not monitored or reflected on the quality of care people received to ensure it was of a good standard. Staff told us the registered manager and providers did not provide clear leadership and they just did what they thought was right. The registered manager did not have the skills to lead the staff effectively.

Staff's responsibilities were not clear, such as who was leading each shift in the registered manager's absence. Staff were not given responsibilities by the registered manager to ensure that the service was delivered safely. On both days of the inspection the service was provided by two care staff of the same grade. One staff member cooked and served the lunch at the same time as giving people medicines and helped people to move from their bedrooms to the lounge or dining room to eat. The other staff member was cleaning the service. Tasks were not shared between staff to ensure that staff had time to concentrate on high risk activities such as preparing food and giving people their medicines.

Systems were not in place to check the quality of any area of the service including, the care people received, staff skills and competence, the environment or health and safety procedures.

The providers had not kept up to date with changes in the law and recognised guidance. The providers and staff were not aware of changes in the way CQC inspect services or the requirements of the Health and Social Care Act 2008. The providers and staff did not know the processes the providers had in place to manage and deliver the service. The providers were unsure if they had policies and procedures for important areas including safeguarding and were unable to locate their policies quickly and easily.

The registered manager did not know what training staff had completed and when. The dates on staff training certificates varied from the dates on the registered managers training schedule. This was a document the provider used to record when staff had completed training. Many of the dates on the schedule were after the dates on the certificates and referred to on line training the provider believed staff had completed. A plan was not in place to ensure that staff developed the skills and knowledge they needed to meet people's needs safely and to an appropriate standard.

Systems were not in place to ask people and their representatives for their views to reduce the risks of people receiving inappropriate or unsafe care. People had not been asked for their views on the care they received. Systems were not in place to obtain the views of staff and other professionals involved in people's care, such as people's nurses and doctors, on the quality of the care people received.

People were not protected against the risks of inappropriate or unsafe care because the provider did not have a system in place to regularly assess and monitor the quality of the service. The views of people, their families and friends and staff were not regularly sought to enable the provider to come to an informed view about the standard of care provided to people. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records could not be located promptly when they were required. Records were kept about the care people received and about the day to day running of the service. A system to archive records so they could be retrieved easily was not in operation. People's records contained all the documents related to their care over the entire time they had been receiving a service at Ashmore House, in some

Inadequate

Is the service well-led?

cases this was several years. This made specific information difficult to find and there was a risk that the most recent pieces of information was not easily available to staff. The providers did not know that they were legally required to register as a data controller with the Information Commissioner's Office (ICO).

The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them. Records could not be located promptly when required, were not retained for an appropriate period of time and were not securely destroyed when appropriate. This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. The provider did not have systems in place to protect service users from the risk of abuse. Regulation 13(1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing. Sufficient numbers of suitably qualified, skilled and experienced staff were not deployed. Staff had not received appropriate training and support to enable them to carry out their role. Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance. The provider had failed to establish and operate effective systems to: Assess, monitor and improve the quality and safety of the service.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Assess, monitor and mitigate risks to the health safety and welfare of service users and others. Seek and act on feedback from relevant persons to continually improve the service. The provider had failed to maintain complete records of decisions taken in relation to service user's care. The provider had failed to ensure that premises and equipment are properly maintained. Regulation 17 (1)(2)(a)(b)(c)(e)
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. Risk assessment had not been carried out in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. The provider had failed to safely manage medicines safely and properly. Regulation 12(2)(a)(g)
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

	Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs People did not receive suitable and nutritious food which was adequate to maintain good health and meet their reasonable preferences. Regulation 14(4)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. The provider had failed to assess people's care needs and preferences. The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. Regulation 9(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect People were not treated with respect and had not their views taken into consideration. People were not given privacy.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints The provider had failed to investigate and take proportionate action in respond to any failure identified by the complaint. The provider had failed to establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints. Regulation 16(1)(2)
	Regulation 10(1)(2)(a)(b)