Life Style Care plc

Ashley Court 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

Overall summary

This was a comprehensive inspection, carried out on 22, 23, 24 and 30 June 2015. The first day was unannounced.

Ashley Court is a purpose built home and is registered to accommodate a maximum of 60 older people who require either nursing or personal care. At the time of our inspection there were 59 people living there.

The registered manager had been employed at the home since September 2014. 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.'

The inspection was carried out in response to information of concern that was received from complainants and the local authority.

Ashley Court had been through a period of instability due to changes in the management of the home and a period where there was no registered manager employed at the home. A registered manager was appointed in September 2014. They told us that they had taken over the home at a time when it was short staffed, existing staff had not been

Summary of findings

supported and training had become out of date. They showed us an action plan with timescales that they had developed after they had had time to assess the issues at Ashley Court.

The feedback we received from people and their relatives and visitors was that staff were kind and they were happy living at Ashley Court.

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

Systems to manage the administration of medicines were not robust and meant that people may not always be receiving their medicines as they were prescribed. We could not be sure that people always received all of the food and fluids they needed to maintain good health.

Safeguarding procedures were not always followed which meant people were not protected from possible harm and improvements were needed in the systems for the prevention and management of infections.

Staff were kind and caring. Not all of the staff made meaningful connections with people and therefore not everyone received person centred care.

People told us they were consulted about their care needs and how they wished to have them met but we found that that assessments of people's needs were not robust, care plans lacked detail and staff did not always follow instructions in care plans.

There was a range of activities available for people in the home which included exercises, quizzes and visiting entertainers. The complaints policy was satisfactory. People told us that the registered manager had an open door policy and they felt able to raise issues as necessary or make a complaint if the need should arise.

Improvements were needed in the way records were maintained and in the systems used for monitoring the quality of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Medicines were not always administered or disposed of safely.

Staff knew about signs of abuse, however incidents of potential abuse were not always referred to the local authority.

Improvements were needed in the systems for the prevention and management of infections.

Staff were recruited safely and there were enough staff on duty to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective.

Some people may not always be supported to eat and drink enough to meet their needs.

People's rights were not protected because some staff did not understand the implications of the Mental Capacity Act 2005 and were restraining some people inappropriately.

A plan was in place to ensure that staff received regular training and appropriate supervision.

Is the service caring?

Requires improvement

Improvements were needed in the way care was provided to people.

Staff did not always support people in a person centred manner and their privacy and dignity was not always promoted and protected.

People and families told us they liked the staff and confirmed that they were consulted about their needs and how they would like to have them met.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were at risk of their needs remaining unmet because assessments were not robust, some care plans lacked detail and staff did not always follow instructions in care plans.

A range of activities were available in the home and there were plans to improve and increase this provision.

There was a satisfactory complaints policy and procedure in place and people told us they felt able to speak out if they had any concerns.

Summary of findings

Is the service well-led?

The service was not always well-led.

Ashley Court had been without strong stable management for some time. The new registered manager had identified shortfalls and was taking action to address these.

People were not protected from the risks of unsafe or inappropriate care because records contained errors and omissions.

A system for monitoring the quality of the service was in place but staff did not always respond to issues that this system highlighted.

Requires improvement

Ashley Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 22, 23, 24 and 30 June 2015. The first day was unannounced. There was a lead inspector present throughout the inspection. A specialist advisor whose expertise was in nursing care for older people was present for one of the days. There was also an expert by experience for one of the days. 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 met and spoke with 11 of the people living in the home. Because a large proportion of the people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with six visiting relatives or friends, the regional director, the registered manager, 13 members of staff and two visiting health or social care professionals.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they planned to make. This was because we brought the inspection forward following information we received. We reviewed the information we held about the home, which included notifications the service is required to make.

We observed how people were supported and looked at eight people's care and support records, an additional three people's care monitoring records and medication administration records and documents about how the service was managed. This included six staffing records, audits, meeting minutes, training records, maintenance records and quality assurance records.

Requires improvement

Is the service safe?

Our findings

The visitors that we spoke with all confirmed that they believed Ashley Court was a safe and comfortable place for their relative or friend to be living in.

Medicines storage areas were clean and tidy and refrigerator temperatures were checked twice a day to ensure that medicines were stored at the correct temperature. Systems for ordering and storing medicines were satisfactory. No items were overstocked and staff confirmed that they rarely ran out of any medicines. Records for the receipt and disposal of medicines were satisfactory. However, medicines that were for disposal were not kept in tamper proof containers and the container on the first floor was overflowing. The staff member in charge of this during the inspection did not appear to understand the process for obtaining additional containers and this had still not been replaced at the end of the day.

The provider's medicine policy and procedure was comprehensive and up-to-date. It did not include information about the storage and security of medicines that are awaiting disposal.

Records showed that all staff who had responsibility for administering medicines undertook regular training and also had their competency to administer medicines checked at least annually. We spoke with two staff who demonstrated a good knowledge of the different types of medicines in use at Ashley Court and their side effects.

We observed two medicines administration rounds. Staff approached people in a professional and caring manner, explained what the medicine was for and asked for people's consent before dispensing the medicine. They did not rush people and seemed to have a good rapport with them.

Over three quarters of the people living at Ashley Court has been prescribed pain relief medicines to be taken as required (PRN). This was good practice for older people especially those who may not be able to express any or the type of pain they were experiencing. There were PRN protocols in place for every person that required one. (A protocol is a system of rules that explain the correct procedures to be followed in clinical situations). These protocols had not been amended to reflect individual needs and therefore they did not include sufficient information to enable staff to judge when a person may need a medicine to be administered.

Some people had been prescribed medicines to help them when they became agitated or distressed. However, there was insufficient detail about how people's agitation or distress was evident. This meant that medicines may not be given to the person at the most beneficial time.

One person had been prescribed a medicine that required staff to check the person's pulse before it was administered. This was because the medicine should not be given if the pulse rate was lower than 60 beats per minute. The person's pulse had not been taken and recorded for the preceding four days. This meant the person was at risk of receiving medicine that they should not have taken.

By the last day of the inspection the registered manager had already taken steps to rectify the issues that we had highlighted. This included reminders to staff about their responsibilities and refresher training in care planning to include the use of PRN medicines.

These shortfalls in the proper and safe management of medicines were a breach of Regulation 12(2)(g) of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014

There were safeguarding adults' policies and procedures in place. Records showed that approximately two thirds of the staff had undertaken training within the last 12 months. The registered manager provided us with a training plan which showed they were aware of staff that needed to attend refresher training and the dates that this was planned for. When we spoke with staff about spotting possible signs of abuse they were knowledgeable and clear about how they would report any concerns that may have.

During the inspection we found records regarding two serious incidents that were unexplained and could have constituted possible abuse. The registered manager had failed to recognise the issue may have been due to abuse and had not made referrals to the local authority.

These shortfalls were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because appropriate action had not been taken in response to potential abuse.

Requires improvement

Is the service safe?

We did not specifically look at infection prevention and management during this inspection. However, we noted a number of issues around the building during the time we were in the home. We found that none of the ensuite bathrooms had rubbish bins with lids. Moving and handling slings had been left in one of the communal bathrooms and one of these had three large brown stains on them which we thought had the appearance of faecal matter. Slings should only be used by one person before they are cleaned to prevent possible cross infection. The slings could have been used by anyone using that bathroom. Light pull cords were discoloured and dirty which may have been a potential source of infection transfer as people washed and dried their hands and then turned off the light by touching the unclean light pull cord. In addition, we found a crash mat and bed rail bumpers that were torn and or stained and a large crack in a toilet pipe. We also found three footstools in the first floor lounge that were covered in wipe clean fabric but this was torn. This meant all of these items could not be cleaned properly.

Almost all of the toilet brushes we looked at were significantly worn and around 50% of these had some brown staining in between the bristles and some had unpleasant looking liquid in the bottom of the brush holder.

These shortfalls in the assessing of the risk of, preventing, detecting and controlling the spread of infections were a breach of Regulation 12(2)(h) d the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

There were enough staff to meet people's needs. All of the staff we spoke with told us that there were times when they would appreciate more staff but they acknowledged that most of the time they were able to provide what they felt was a good standard of care. The registered manager explained that staffing levels were calculated with the use of an assessment of people's levels of dependency but could be increased quickly on a short term basis if people's needs suddenly increased such as if there was illness in the home. The registered manager also advised that, following their appointment to the position nine months ago, they had found the home to be short staffed so had had to use a high number of agency staff whilst trying to recruit permanent staff to the home. Both the registered manager and staff in the home all noted that it was often harder to provide a good standard of care on a shift with agency staff because they did not know the people they were caring for or the routines and expectations in the home. Analysis of the staffing rotas showed the use of agency staff was decreasing.

Satisfactory recruitment procedures were in place. The required checks were undertaken before staff started work and records contained proof of identity, including a recent photograph, and the other information which is required by the Regulations.

There were systems in place to identify risks to people. Risks were assessed and plans were implemented to reduce risks. These were reviewed regularly. Risk assessments were in place for areas such as the risk of falls, moving and handling, malnutrition and pressure area care.

The premises and equipment were managed to keep people safe. A maintenance person was employed for 40 hours per week. They carried out general items of maintenance and also coordinated all the regular checks by other companies such as the service of the fire warning system and passenger lifts. There were up to date risk assessments for the prevention and management of fire and legionella and satisfactory plans were in place for the continued care of people in the event of an emergency such as damage to the building or power failure.

Requires improvement

Is the service effective?

Our findings

People who were able to speak with us told us that they felt supported to live their lives as they wished. One person had been given a room on the ground floor as they especially enjoyed being outdoors whenever possible and could have free access to the secure garden at the rear of the home.

The majority of staff were skilled at developing a rapport with people and thereby enabling them to have positive interactions even when their understanding was limited or communication was difficult. However, we also saw some staff who appeared task foccussed rather than ensuring the wellbeing of the person. For example, on the second day of the inspection, one person had support from a staff member to eat their lunch in a very sociable and positive manner and the staff member was patient and caring. The person ate their entire main course, had two puddings and drank well although their care plan reflected that they were frequently agitated and may refuse to eat. On the third day a different staff member was supporting the person. They did not did not speak with or interact with the person who had been calm when they came to the dining room but started to become agitated and get up from their chair. The staff member did not respond to them or interact with them and eventually the person left the table having not eaten anything. We saw other similar situations in other parts of the home. The registered manager told us that they were aware of this and had booked training courses on developing understanding of dementia and providing person centred care.

Lunchtimes on each of the floors in the home were busy with a high proportion of people requiring assistance and supervision. Those who wished to eat in the dining room either made their own way there independently when staff told them it was time for lunch or those with mobility difficulties were assisted there by staff before they began to serve the meal. Staff worked hard to serve meals whilst they were still hot. However, we saw that those people who also needed support to eat had to wait up to 40 minutes before staff were available and during this time they sat with the sight and smells of food around them and watched other people eating. Some people remained in bed for their lunch and others stayed in specialist chairs. Some people did not appear to have been repositioned before their meals so that they were in the most upright position they could be in. Care plans for two of these people included instructions to ensure people were as upright as possible to avoid any risk of choking.

Most staff took care to explain to people what the meal was but some people had meals placed in front of them with no explanation or interaction from the staff member. There was a choice of two main meals and two puddings. Staff had supported people to make their choices for the main course the previous day. People were offered a choice of puddings as staff either asked people what they would like or took both puddings to people so that they could make a choice. During our observations we noted that no one was offered salt, pepper or any other condiments. Drinks of water or squash were already placed on tables. This meant that many people were not offered a choice of drink although we saw that there was a choice of cordials available in the kitchens on each of the floors. Some people told us that they enjoyed their meal and it was evident that many others had enjoyed the food because they readily accepted “seconds” when it was offered.

The provider, through the use of an assessment tool, had identified that some people were at risk of malnutrition or dehydration. These people had their weight, food and fluid intake monitored. However, we could not be sure that people were receiving all of the food and fluid they needed or that the records were accurate. One person had lost seven kilograms in three months. Their record stated that they should be weighed weekly but the most recently recorded weight in their care plan was more than a month before. In addition, daily records showed that the person was vomiting frequently. We later found that the person had been weighed more recently but the record was kept on a piece of paper in the office, rather than in their care plan. Staff had not undertaken a review of the person’s weight loss. A senior member of staff confirmed that this had not been done and that a referral to the GP and Speech and Language Therapists should have been made.

Many of the fluid charts did not contain a target amount for people to consume to ensure they did not become dehydrated. Where targets were set these were generic and did not take into account people’s individual needs. For one person, fluid charts did not have a target amount of fluid recorded and there were eight consecutive days where the totals recorded were very poor and meant the person was at high risk of becoming dehydrated. During the

Requires improvement

Is the service effective?

second day of the inspection we observed that the person refused all food and fluids during the lunch hour and was sleepy and withdrawn. We later checked the food records which stated that they had eaten half of the vegetables, three quarters of the potato and all of the meat from the main course and all of the pudding.

There was no information in care plans about what to do if people failed to have sufficient food and fluid and there were no entries in the daily records that we looked at about any actions that had been taken to encourage people to eat and drink better.

These shortfalls in assessing, planning and meeting people's nutrition and hydration needs were a breach of Regulation 9(3)(i) of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that they had received training in the Mental Capacity Act 2005 and told us they understood how it should be used in practice. People's care plans contained information about decision making and where people lacked capacity to make a decision for themselves, staff had used the Mental Capacity Act 2005 guidance to ensure they made decisions in the person's best interests. There were mental capacity assessments and best interests decision making records in people's individual care records to support this. For example, some people who lacked mental capacity refused to take medicines which they needed to keep them healthy. There were detailed assessments which had included GP's, social workers, families and other relevant parties to decide whether medicines should be given covertly. The best interests decision and the plan for doing this had been clearly recorded.

However, where people needed to be restricted for their own safety, decisions and instructions were not so clear and raised concerns that the technique of "safe holding" may be used more frequently than necessary. For example, the assessment and best interests decision for using safe holding with two people stated that it was because the staff needed to ensure their personal care needs were met. There had been no consideration of delaying personal care for a period of time or setting a time limit on the length of time a person could safely be left without personal care which would have been a less restrictive solution. In addition, we found that some staff were recording they had used safe holding when they had not received suitable training or where the person had not been assessed as requiring this. The registered manager stated that they had already identified that further training was required and showed us a training plan that had been drawn up to support their statement. They also confirmed that they would not expect safe holding to take place if people had not been assessed as requiring this and staff had not been trained to use the methods safely. This meant that for the people we identified best interests decisions about the use of "safe holding" had not been made in accordance with the Mental Capacity Act 2005.

The failure to act in accordance with the Mental Capacity Act 2005 and to use restraint inappropriately was a breach of Regulation 13(4)(b) of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood when an application should be made and how to submit one and was aware of a 2014 Supreme Court Judgement that widened and clarified the definition of a deprivation of liberty. Applications had been submitted to the relevant local authority for a number of people and the home were waiting for assessments to be carried out. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Ashley Court is a purpose built home and comprises three separate units, one on each floor of the home. There was a garden at the rear of the property with features including an aviary and a fish pond as well as lots of seating. Each unit had a separate lounge and dining room as well as specialist bath and shower rooms. All rooms had ensuite facilities and some of these included a shower. Many areas of the home, including lounges, dining rooms, corridors and some bedrooms had bare walls and little personalisation. Much of the paintwork was worn and chipped. The bathrooms were sparse with notices taped to the walls and harsh lighting. This would make it more difficult for staff to make bathing into an enjoyable experience. One member of staff told us that they "didn't blame people for refusing to bath". The registered manager told us that they had raised the need for refurbishment of the home with the provider and that she and the staff were always trying to improve the feel of the home with personal touches such as pictures and ornaments.

Requires improvement

Is the service effective?

We recommend that action is taken to review with regard to best practice guidance about creating dementia friendly environments.

Various health professionals including GPs and care managers from social services visited the home during the inspection. During the second day of our inspection one GP was spending time in the home carrying out Over 75's checks for a number of their patients. All of the professionals confirmed that the home always sought advice and support appropriately and that staff acted on any instructions that were given meaning that people received the health care that they needed.

Staff confirmed they received support and supervision. The registered manager acknowledged that, due to the changes in management, the frequency of supervision was not in line with the home's policy and confirmed that a plan was in place to address this.

Staff told us they also had training provided which had increased their knowledge and understanding and therefore enabled them to improve the care they provided. Detailed induction training was provided in line with national standards. Training records showed that refreshed training and competency assessments for some staff in some of the essential areas such as moving and handling, safeguarding adults, dementia awareness and health and safety were overdue and there was a management in place to address this. We discussed mental capacity, deprivation of liberty and safeguarding training with one member of staff who told us, "In meetings and supervision we are always reminded about these three and I think it is important we are, after all it's the resident's freedom that is at stake and their ability to make their own decisions".

The registered manager also told us about the reflective practice processes that they had introduced into the home. This involved staff completing a form following any training or an event or incident, to look at what had happened, why it had happened and any learning that could be shared within the home.

Requires improvement

Is the service caring?

Our findings

All of the visitors that we met told us that they were always made to feel welcome in the home and were included as much as they wished to be with day to day life in the home. They also said that the staff were always friendly and helpful and they were happy with the way their relative or friend was being cared for.

We observed that people mostly received care from staff who were skilled at developing a positive connection with them which ensured that people's needs were met in a caring and person-centred manner. For example, one member of staff sat with four people at a table for the whole of the lunch period. They turned the mealtime into a social event and provided the support people needed in an unobtrusive manner. Everyone on the table ate and drank well and we heard lots of laughter and saw lots of smiles.

However, some staff lacked these skills which meant that some people did not always have a good experience of receiving care. For example, some people required a soft diet and meals were pureed. These were nicely presented with each item pureed individually and looked appetising on the plate. Some staff assisted people and told them what they had put on the spoon for them to eat but others mixed all of the items into one and then tried to assist people to eat with no interaction at all. We noted that these people did not eat as much as the people who had interaction with staff. We also saw one person was very sleepy during their meal. Staff repeatedly came and told them to wake up and eat their meal but then went away again. The person did not seem to understand staff and looked confused each time before falling back asleep.

These failures to provide person centred care were a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

People's privacy and dignity was not always respected. Staff took care to ensure that doors were closed when they were assisting people with personal care. They also used a sign to hang on the front of the door to prevent people disturbing them. Staff told us how they used towels to keep people covered as much as possible during personal care and screens were used in the communal areas if people needed to be hoisted into and out of wheelchairs. However, we noted that just inside each person's bedroom door, there was a Perspex holder for people's daily records. During each day of the inspection we saw that almost all of the holders also contained a stock of new continence pads. In addition, some people had specific needs with regard to positioning, exercises, eating and drinking or moving and handling. Notices had been cellotaped to the walls in people's rooms or over the display box just outside of their room which gave instructions to staff about meeting these needs. None of these practices enhanced the privacy and dignity of the people living in these rooms.

We recommend that these practices are reviewed and different methods of ensuring staff are aware of people's needs are implemented to ensure that people's privacy and dignity are respected.

We noted that the activities organisers had a good knowledge of people's lives before they moved to Ashley Court. This included the meaningful people and relationships in their lives as well as their previous occupation, likes and dislikes. This meant that they were able to strike up conversations, develop a rapport and make people feel reassured very easily. Whilst most of the information they had was in people's care records, we found that not all of the staff had the same knowledge of the people they were caring for which may have made it harder for them to make positive connections with people.

The registered manager told us that they were aware that some staff needed to improve their skills and had requested in-depth training to develop their understanding of dementia, the different types, stages and symptoms as well as the best way to provide good care for people. Some staff had already attended this training. They told us how it had included experiencing life with limited, sight and hearing and people they did not recognise talking to them and trying to make them carry out tasks. They said the training had given them an insight into what it may be like to live with dementia and had made them review their practice.

People and visitors confirmed that they were consulted about their care needs and how they wanted them to be met and were able to contribute to reviews and care plans. The registered manager had identified that some people did not have anyone to help them to understand decisions that had to be made or enable them to make an informed decision. They had therefore made referrals to advocacy organisations and three people had Independent Mental Capacity Advocates appointed to assist them.

Requires improvement

Is the service responsive?

Our findings

People told us that the staff were kind and helped them when they requested assistance. Visitors told us that they felt the staff listened to them and kept them up to date with any changes in their relative's health or care needs.

Each person had a care plan. The care plans showed that people's needs had been assessed and care had, to some extent, been planned to meet their needs. Care plans included information about people's personal history and individual preferences such as whether they preferred male or female only carers. Risk assessments were also completed. The provider's policy stated that care plans should be reviewed on a monthly basis or if a change in need occurred. The care plans we looked at were up to date. Some care plans lacked detail which meant staff may not have important information about how to meet particular needs. For example, some people had diabetes and others suffered from epilepsy. Care plans did not contain information about how the home should manage people's diabetes, the acceptable ranges for blood sugars, the foods that should and should not be consumed over a 24 hour period and the possible risks and complications of not observing health guidelines for diabetes. With regard to people with epilepsy there was no information in the care plan about the type of epilepsy, the usual length of a seizure, the action to take when a seizure occurred, how long a seizure should last before emergency assistance from paramedics was requested or any rescue medicines that were held in the home and could be administered by staff.

We found some care plans gave clear instructions about how care was to be provided but our observations and analysis of daily records showed that these instructions were not always being followed. For example, staff had requested assistance from community mental health services for someone who was very agitated and could exhibit behaviours that challenged others. A clear care plan had been provided following the assessment from the community mental health team which included recommendations to find out about their previous enjoyment of music, have one to one chats about the past and regular one to one trips into the garden. Analysis of the previous three weeks records showed that the person had only been taken to the garden once, there was no indication that any research had been done about their interest in music and no evidence that one to one chats had been used to help the person when they were agitated.

Staff had recorded in some people's daily records that they had been "aggressive". However, this had not prompted staff to start a behaviour recording chart so that triggers to the incidents could be identified and a plan of care put in place. There were behaviour recording charts for some other people but these were not properly completed and therefore did not give the opportunity for staff to review the incidents to establish possible triggers.

These shortfalls in the accurately assessing, planning and meeting people's care needs were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two activities staff were employed in the home. The registered manager told us that this had recently increased as, since their appointment as manager, they had identified that the provision of activities was limited and there were not enough staff to carry out the role. The activities staff told us they were reviewing the programme of activities to ensure that it met people's needs. We saw that the home was equipped with various indoor games such as carpet skittles. Entertainers such as singers and musicians were regularly invited into the home and a birthdays were celebrated with a homemade cake provided by the chef. Some people had recently been on a boat trip around Poole Harbour. Regular activities within the home included arm chair exercises, quizzes and arts and crafts. The registered manager told us that there were plans to further develop activities to ensure that people were able to take part in meaningful and stimulating activities.

There was a complaints leaflet available in the main entrance and on the visitor's notice board. The leaflet clearly set out how a complaint could be made and the response that should be expected regarding investigation processes and timescales. Records for complaints contained information about the investigation, outcome and any action taken to ensure that any learning or improvements as a result of the investigation were made.

Requires improvement

Is the service well-led?

Our findings

Ashley Court had been through a period of instability due to changes in the management of the home and a period where there was no registered manager employed at the home. A registered manager was appointed in September 2014. They told us that they had taken over the home at a time when it was short staffed, existing staff had not been supported and training had become out of date. They showed us an action plan with timescales that they had developed after they had had time to assess the issues at Ashley Court.

We saw that people recognised the registered manager and were comfortable in approaching them and raising issues with them. We saw that the registered manager knew all of the people in the home and had a good understanding of their individual circumstances. Visitors told us that the registered manager, senior staff from the home and regional staff were approachable and listened to them if they needed to discuss anything.

Some records relating to people's care and to management of medicines lacked detail or were incomplete. For example, food records did not clearly show what people had eaten or the quantity. Medicine records did not always clearly indicate when PRN medicines should be administered. We also found that a chart was used to record the different types of care given to each person over a 24 hour period. This included hair care, nail care, shaving and other personal interventions. The chart had a number of different codes for staff to use to indicate when and what care had been given. We found staff were using a code that did not exist on the key for the chart and none of the senior staff or registered manager were able to tell us what the code meant.

There were four occasions during the inspection when we needed to speak with the nurse in charge of the floor that we were on. We could not find them and staff we asked did know of their whereabouts. We found that there was one photocopier in the building which was in the main reception office on the ground floor. The nurses explained to us that most of the documentation they completed was paper based and they often need to take copies and fax prescription requests which can only be done in the main ground floor office. This meant that the nursing staff were leaving the floor and therefore reducing staffing levels on each floor. The registered manager confirmed that they were trying to reduce this issue by installing fax machines on each floor but that this was taking time to address because of wiring issues.

The shortfalls record keeping were a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems to monitor the quality of the service and identify any concerns were in place. There were policies and procedures for monitoring the quality of the service. Processes included identifying areas for improvement, taking corrective action where issues were identified and reviewing practices to prevent recurrence of any issues.

There was a detailed programme of auditing carried out either by senior staff and the registered manager or by regional managers and specialists. Audits included accidents and incidents, health and safety, the premises, infection prevention and control, cleanliness and medicines. A regional advisor for moving and handling had undertaken an audit of moving and handling equipment and people's moving and handling care plans. Another regional advisor had carried out comprehensive audits of care plans. A regional manager also carried out regular unannounced spot checks of the home. Records identified where any shortfalls or concerns were identified and detailed the action to be taken to correct the matter and also try to prevent any re-occurrence.

The audit of care plans had given staff detailed instructions on the corrective actions they should take to ensure that the care plan reflected the person's needs and the care that was to be provided. However, we found two occasions where an audit had been undertaken 19 days previously but the corrective actions had not been taken by the staff which meant that the care plan did not reflect the person's needs or how their needs were met. In addition, we found issues with regard to the medicines management and infection control which had not been identified during the provider's own audits.

We recommend that audits and checks are reviewed to ensure shortfalls and matters of concern are identified and corrective or preventative action is taken in a timely manner.

Observations during our inspection and feedback from people living in the home, visitors and staff showed us the home had a positive and caring culture. This was because

Requires improvement

Is the service well-led?

there were regular opportunities for people to contribute to its day to day running through informal discussions, resident and relatives meetings, and regular surveys of people living in the home, relatives and health professionals.

One member of staff told us, “The manager is very enthusiastic and kind, she is often around the building and wants to know what is going on”. Another member of staff told us, “I have been here for about a year and I am very impressed with the way the home is organised…Our opinions are asked for and action follows that shows to me that the manager and deputy care about what we think and our thoughts are important”.

Staff knew how to raise concerns and were aware of whistleblowing policies and procedures. Staff told us they felt supported and able to raise concerns should they have any.

There were satisfactory arrangements in place to ensure that there were regular checks of the building and equipment. Maintenance contracts were in place for items such as the passenger lifts, fire warning system and specialist equipment such as the baths. There were up-to-date certificates for safety checks on the gas and electrical system.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risk associated with the unsafe management and use of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Action had not been taken in response to potentially abusive situations.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risks of infections.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Proper steps had not been taken to ensure that people received person centred care and support they required to meet their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not protected against the risks of inadequate nutrition and hydration.**

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 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Proper steps had not been taken to ensure that people were cared for in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's needs were not accurately assessed and planned for.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People were not protected against the risks of unsafe or inappropriate care because accurate records had not been maintained.**