Ideal Carehomes (Number One) Limited

Ashworth Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Ashworth Grange took place over two days, 9 and 16 January 2017 and was unannounced on both days. The previous inspection in June 2016 had rated the home as requiring improvement with an inadequate rating in the safe domain. The home was in breach of three regulations relating to good governance, staffing and safe care and treatment. We issued warning notices for the latter two areas as there were serious concerns about the lack of improvement seen over the previous six months. During this inspection we looked to see if improvements had been made.

Ashworth Grange is a 64-bed home which provides accommodation over four units, two of which particularly care for people living with dementia. On the days we inspected there were 42 people in the home.

The home had a manager in post who was applying for registration. They were present on the first day of the inspection and half the second day. 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.

This inspection found some improvements had been made but there were still serious issues in regards to medication and risk assessments. In addition, there were also issues with the assessment of mental capacity.

People and families said they felt safe and staff demonstrated a sound understanding of what may constitute poor practice, and knew how to report this.

Despite the issuing of a warning notice following the previous inspection the home had still not provided evidence of personalised moving and handling assessments for people and neither were they able to show us equipment checks on hoists or slings as required under the Lifting Operations and Lifting Equipment regulations. This meant people were at risk of harm as the necessary safety checks were not completed and equipment may have been used which was not appropriate for that individual.

Staffing levels had improved and we saw better response times for people in relation to the call buzzer. This information was analysed closely by the manager and investigated where there had been issues.

Serious concerns remained in regards to medication, both for administration where procedure was not always correctly followed and in storage where, again, we found one of the medication trolleys broken.

Some staff training had elapsed but we saw actions in place to tackle this prior to our visit following an audit and the implementation of a new supervision schedule had recently commenced.

The completion of mental capacity assessments was inconsistent and many were void as they were not decision-specific and had been completed incorrectly. There was no evidence within people's care records of appropriate authorisations where people had consented on behalf of others to show they had the permission to give consent on someone's behalf.

Nutrition and fluid intake were better managed although there were gaps in recording in some units. We saw people at risk were supported regularly with extra snacks and drinks, and also referrals to external professionals made as necessary. Pressure care relief was generally also improved although we observed one person without their required pressure cushion.

Staff were patient and kind in their interactions with people, and attentive to their needs. We found communication was clearer as staff discussed what they were doing and handover notes were more comprehensive.

Care records were detailed and person-centred, showing evidence of regular evaluations. Daily notes also reflected people's days and correlated to other parts of the record where necessary, such as an increase in falls and contact with a GP to rule out infection.

The home had a new manager who had been in post for two months and it was evident they had already had a significant impact. Staff spoke with us of changes and feeling more included in decisions which was helping rebuild morale. Audits were more effective as tools to identify areas needing further development but there remained concerns around medication and risk assessments.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were still significant issues with medication administration and storage which had been present at the last inspection.

Risks in relation to moving and handling were not managed well as staff had no guidance to follow.

People and relatives told us they felt safe and knew how to report any concerns.

Staffing levels had improved and there were sufficient numbers of staff to meet the needs of the people at the home and needs were met more promptly.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported well with their nutritional and hydration needs, and we saw improved practice. However records were sometimes lacking in detail.

People who lacked capacity were not being correctly assessed and the process for best interest decision-making was not being followed in line with the Mental Capacity Act 2005.

Staff had received some supervision and training but gaps had been identified and this was an ongoing process.

People had access to external health and social care support as required, but guidance was not always followed in relation to pressure relief.

Is the service caring?

Good

The service was caring.

We observed people receiving care from patient, kind and compassionate staff who aimed to meet their needs.

People were offered choices and encouragement, and we saw staff were able to respond effectively if people became agitated.

Privacy and dignity was promoted on each day and staff were aware of ensuring people were spoken with discreetly if necessary.

Is the service responsive?

Good

The service was responsive.

People had access to a wide range of inclusive activities and we saw positive engagement from carers on a one-to one basis, which we had not observed previously.

Care records were detailed and reviewed regularly.

The home had not received any complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been significant improvements to the home since the arrival of the new manager, with a more effective use of audits tools.

People and staff were happy with the general changes and could see the benefit of these.

However, there remained serious concerns with the areas we had raised at the previous inspection, namely medication and risk assessments.

Care Quality Commission

Ashworth Grange

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 9 and 16 January 2017 and was unannounced on both days. The inspection team consisted of two adult social care inspectors and an expert by experience on the first day, and one adult social care inspector on the second day. The expert by experience had many years' experience in health and social care management.

Before the inspection the provider completed a Provider Information Return (PIR). 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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service.

We spoke with six people using the service and four of their relatives. We spoke with four staff including one care worker, one senior care worker, the activity co-ordinator and the manager.

We looked at six care records including risk assessments, five staff records, supervision records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

One relative told us "What's really good is if there are any incidents – however trivial – they always tell you. I feel my relation is safe and happy here. I am happy with this being their new home and so are they. I trust them (the staff) – there's always someone in the lounge." Another relative said "My relation is happy, safe and clean here. I visit every day. The food is nice and I've eaten here too." A further relative said their relation was "no longer frightened or anxious."

One staff member told us "People are safe as they are all well looked after. My role is to make sure people are safe and protected. Some clash and we keep them separate and reassure them. They do argue." When we asked them what may be a safeguarding concern they said "It could be verbal, physical or mental abuse. I would fill in an ABC (behaviour) chart and report it to the manager. If nothing changed I would whistle blow." Another staff member said "It could be medication not being given or someone being supported to stand with one carer when there should be two." Both staff said they had raised concerns about other staff before and these were dealt with effectively. We saw notifications to the local authority and ourselves had been made as necessary and action taken with staff if they were implicated in the concern.

During the previous inspection we had serious concerns about medication, especially the timing of the morning medication round for people, storage of medication and administration practice. We found the same issues on this inspection.

We checked both treatment rooms where medication was stored in trolleys. In the downstairs medication room we found one of the trolleys had a broken lock as the key had snapped off. The staff member advised us this had been reported to the pharmacist but we did not see any documentary proof of this. In the upstairs treatment room one of the trolleys had a bent key in the lock although it was usable. When we discussed this with the manager they advised us they felt the issue was due to poor manoeuvrability of the trolleys and staff catching keys on the doors. They accepted the keys should not be in the locks when trolleys were being moved around the home and agreed to raise this with staff as a matter of urgency.

Before the administration of the medication in the downstairs unit for people with dementia we observed the staff member removing all the medication from the broken trolley into the other which locked. This was at 11:25am and yet some people had still not received their morning medication. One person had been complaining of being in pain at 10.30am. Medication was not given until 11:40am on this unit. We saw they were prescribed a painkiller to be taken up to four times a day if needed. However, although the medication was given, there was no record of the time it was administered. This meant the second dose (if needed) would have had to wait until much later in the afternoon as this medication could only be given at four hourly intervals. It also meant staff were not aware of when the tablets had been given, risking the chance of over medication. We brought this to the care manager's attention who agreed to investigate.

We observed staff administering medication which was done patiently. If a person was still asleep, the staff member left the Medicine Administration Record (MAR) sticking out of the file as a prompt to show they had not received their medication. Early morning medication such as lansoprazole which needs to be taken at

least 30 minutes before food was highlighted on the MAR to enable night staff to administer this and we found this had been recorded as administered. However, when we checked MAR sheets we had concerns about gaps in recording and the use of codes which did not correspond with the specified key, meaning staff may have misunderstood what had happened. Although people's MAR had their photograph, room number, GP and allergy details, we saw some completed with the code 'W' which we were told by the staff member was 'withheld'. When we asked why this had been withheld, we were told this was because the person was unwell but there was no evidence of any further follow up to see if it had been safe to withhold the medication. In other records we saw 'z' which one carer told us meant asleep and then changed their explanation to 'discontinued'. However, there was no evidence to support either definition which meant staff would not be clear as to what had happened.

We were told one person often refused their medication and the staff member told us "I offer it first and if they don't take it I put it in milky coffee. I crush it." There was a letter in the person's medical notes from the GP to agree to the covert administration of the medication but it did not indicate how this was to be done nor that it was considered safe to crush the medication. This could have seriously impaired the effectiveness of the medication. The best interest decision meeting in regard to this concern did not include the pharmacist to determine if the medication could be given safely in a hot drink or give direction to staff as to how the medication should be given as required under the National Institute for Clinical Excellence (NICE) guidelines.

If a person refused their medication this was noted on their medication administration record. When we asked staff what action would occur if they kept refusing, one carer said "We would ring the GP and they would put them on covert medication." They said the GP had to sign and the family would be informed. We asked them about the completion of a capacity assessment they were unclear if this was completed. We did not find any capacity assessments relating to administration of medication which demonstrated the home was not following the requirements of the Mental Capacity Act 2005 in this regard.

The home had had two admissions just prior to our inspection and in both instances we found little evidence of detailed pre-admission assessment. One person's had no record of any medication and yet we found staff administering this. When we asked the staff member administering medication about this person they said "I don't know how they take their medication, with ease or what."

Protocols were in place for PRN (as required) medication but not all were completed in full. Some did not include information regarding how a person showed pain if they were unable to verbalise. This meant staff did not have the necessary guidance for knowing when to offer a person specific medication. We found creams and eye drops were not dated on the date of opening, meaning staff could not be sure when they had reached their expiry date. These examples all illustrate a continuing breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not being kept safe when medicines were being administered due to multiple issues with storage, guidance and administration.

We checked the treatment rooms and found room and fridge temperatures were recorded on a daily basis. Staff were wearing appropriate personal protective clothing while supporting people with their medication. However, there was nowhere on the trolley assigned to dispose of used PPE which meant it was stored in the 'do not disturb' tabard posing an infection risk.

We saw staff had had their medicine competency checked. This included specific training, observations while administering medication and a questionnaire. However, we saw these had not all been marked and so there was no indication whether a staff member had reached the required standard. All medicines were ordered by the deputies or the care manager.

Risk assessments continued to lack clarity around methodology. In one person's record it was noted "[Name's] mobility has become poor on an evening. Staff can use stand aid if required due to poor mobility." No other information was noted such as how staff were to support effectively or methods to use the stand aid safely. In the same care plan we noted their falls risk assessment had been updated on 21 December 2016 stating they had had no falls in the past year. However, in the same file there was a record of a fall on 14 December 2016 for which an accident form had been completed. This meant the completion of the falls risk assessment was incorrect as it did not reflect recent events, and the risk total had been added incorrectly giving staff misleading information.

In another record, which we had brought to the attention of the previous registered manager at the last inspection, we saw a manual handling assessment which stated "hoist, sling type – medium" and which loops were to be used. However, there was no specific sling identified, the hoist wasn't specified, and there was no mention of any other equipment in use except a 'wheelchair', again with no information as to whether this was the person's own. This meant staff did not have clear guidance to follow. We checked this person's room and found two slings in situ, one of which had a serial number and the other was a medium access sling whose serial number was unreadable although it did have the person's name on it. There was also a shower chair and commode neither of which had been mentioned in their care record.

We asked staff whether they were given any guidance on moving and handling apart from the training they attended. One told us "I imagine the deputies or managers write the care plans and moving and handling risk assessments. I have never seen any method written down." We observed staff moving people using the hoist and saw they were safe in the procedure. They provided reassurance and explanations to people throughout the process to eliminate the level of distress. People's dignity was also preserved as blankets were placed over people's legs. We were not provided with evidence to confirm equipment had been checked despite us asking for this on more than one occasion which meant equipment may not have been safe for use.

People had care plans for skin integrity but in one person's record we noted they had a high Waterlow score, meaning they were at risk of skin breaking down and were required to sit on a pressure cushion to reduce the risk of harm. However, we observed mid-morning on the first day they were not. This meant the person was being put at risk of skin damage as appropriate equipment was not being used to support them. Their care plan had been evaluated monthly and their needs had not changed saying they required two-hourly pressure relief and 'staff were to closely monitor'.

We looked at the records of a person who had only been in the home since 6 January 2017. The resident details form only contained details of their GP and next of kin. It was not signed or dated. The pre-admission statement was equally brief based on details provided by a social worker whose contact details were not recorded. One line answers for questions around health and wellbeing, skin integrity, personal care, food and mobility were recorded.

This was significant as the person was found on their bedroom floor having 'slipped out of bed' according to their daily notes on 8 January 2017. They were fortunate not to have incurred any injuries but there were no risk assessments in place to ascertain this person's mobility, cognitive function or recent infection history all of which may have contributed to the fall. It was noted they had a history of falls but there was no risk assessment in place to manage this and also that they suffered with short term memory loss. No information about their medication was recorded and we saw the out of hours GP had been contacted the day after admission to ascertain what medication they should be on as their blister pack did not indicate what this should be. These examples illustrate a further breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home was not doing everything it possibly could to

assess and mitigate the risks to people when transferring them with specialist equipment.

Staff were able to explain different risk measures they used on a daily basis. One carer said "I make sure people are using their walking frame properly, that drinks are the right temperature, that equipment is used when needed such as the stand aid or hoist and people get offered help with continence care as often as needed."

One staff member told us how they dealt with falls. They said "I would press the emergency buzzer on finding someone and never move them, especially if there was a head injury. I would call for an ambulance. I would complete the accident form and share the information with managers. We would also put 72 hour observations in place following a fall to ensure they were OK." We saw in care records detailed evidence of falls with actions taken where necessary. The manager said falls numbers had been reduced as staffing levels increased as people were being monitored more effectively.

Accident analysis had been completed on a monthly basis but varied in quality. Accidents were logged as to the location and time of incident, and some attempt made to link to staffing levels at the time. Direction was given to staff where there were particular people at risk and incident records were completed for individuals. We saw action had been taken such as a referral to the falls team, equipment put in place to minimise the risk of harm to a person such as a crash mat and medication reviews to be undertaken by the GP. However, we noted not all accidents were recorded in the central system and not all had been reported to the Care Quality Commission as required.

We spoke with people about staffing levels. One person said "I don't ask for a drink, I wait until it's the time for it to come round. If I want or ask for something, there's usually a delay. Sometimes it's just the waiting that irritates me." We did not observe the delays we had seen on the previous inspection, partly due to the lower number of people in the home. The manager was in the process of implementing individualised dependency tools to help better track people's level of need and to allow the adjustment of staffing levels accordingly. A more basic tool which considered people's mobility, communication and cognition, nutritional risk and falls among other factors was currently used to determine staffing levels. This showed only eight people required two staff to transfer and four had problems sleeping. This meant the variance of needs had diminished in the home, reflecting in better response times by staff.

We did note managers came and sat in the communal lounge areas while staff supported people with personal care and the seniors administered medication, although there were odd periods when the lounges were unstaffed. This appeared to be planned cover which showed it had been addressed since the previous inspection. This observation helped prevent some episodes of agitation increasing and provided general support for the more active people.

Staff were allocated a unit to work in which meant there were two care staff per each unit and one senior for the ground and upstairs floors respectively. On the first day of the inspection there were more staff working than on the second with an additional 'floating' carer. The second day was affected by sickness to which one staff member said "People are still ringing in sick. It would be fine if they didn't do this. It's not helpful to the team."

Ratios remained the same at weekends and there were five staff working overnight to ensure each unit was covered and one staff member 'floated'. Staff told us they were asked to cover the occasional shift but never forced, and managers often helped out. The manager told us they never used agency staff. In addition to the eleven care staff there was a deputy and the care manager along with the manager which provided additional support as needed.

We checked staff recruitment files and found all necessary checks had been conducted prior to employment. Interview notes were within staff files and showed in depth questions and role play scenarios to ensure staff recruited had the right aptitude for the post. References were requested and identity checks carried out including DBS (Disclosure and Barring Service) Checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at call bell response times and saw significant improvement in these based on the findings from the previous inspection. Each call was logged and an investigation took place where responses times exceeded five minutes. The manager said when they first started there used to be up to ten calls day which had taken over five minutes to respond to but now it averaged two. In each instance it was evident where staff had been otherwise engaged.

Staff were able to describe the fire evacuation procedures and had regular drills which meant they were clear what to do in an emergency.

We observed improved infection control practice as staff were wearing personal protective equipment at appropriate times and one staff member told us what precautions they follow if a person was suspected to have an infection. The manager told us, and we saw, the implementation of a more thorough infection control tool which the housekeeper had responsibility for.

Requires Improvement

Is the service effective?

Our findings

One person said "There's a good choice of food here, you can have what you ask for" and another told us "I like the food." A further person said "If there's nothing I like on the menu, I can ask for something else and I'll get it."

Breakfast was flexible on time and choice, though one person was left waiting for some time as the carer had left the room and we had to ask the activities co-ordinator to get their meal which they happily and speedily did. Where people struggled to make choices, staff showed them different options such as a pot of jam to have on their toast. This showed a good awareness of how to support effective decision-making.

People had access to jugs of juice, crisps, chocolate bars and other snacks which were left on a side table and we saw drinks being offered on a regular basis throughout the day. Lunch was well organised and personalised with sufficient staff to meet need; it was freshly cooked and looked nourishing. If people were not keen on what was on offer, they were encouraged to ask what else they might like and alternatives were offered.

There was a high level of responsiveness and personalisation at lunch time though there was no visible menu and the condiments were in small individual plastic sachets which people couldn't open. One person was struggling with their appetite and fluid intake. They had not eaten breakfast and barely sipped any fluids although staff had provided both drinks and food. It was only at lunchtime when one carer focussed in a more concentrated way on their needs that they managed some liquid and a small amount of food.

Staff told us people who were nutritionally at risk were on food and fluid charts. One staff member told us about three people in one unit and we checked these people's nutritional records. They explained the records were analysed on a weekly basis by the care manager who would review if people were being supported effectively. We noted in some units file recording was variable with gaps in entries for meals and where short term care plans were in place for people, they did not provide guidance to staff as to how support people effectively.

We saw on more than one occasion reference to 'good diet' and we asked one staff member what this meant. They told us it meant five or six glasses of fluid or that the person had eaten all their meal. However, as people's portion sizes varied and it was no record of calorific content this was not an accurate way to record nutrition. They were aware one person responded better the less food was on their plate and would always offer them more if they finished this. We observed people being encouraged to eat in line with their nutritional care plan.

One person had been noted in their care record as having lost weight and was on a food and fluid chart. It was noted staff were to encourage high calorific food and the GP had been informed. Weekly weights were recorded and it was evident the person was putting weight on. There were two people who had had significant weight loss over a six month period but we saw the reasons for this noted and actions taken to try and limit further weight loss. This demonstrated weight monitoring measures were being followed

effectively.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found people had mental capacity assessments in their care records. However, these were not completed in line with the requirements of the legislation. In one record there was a mental capacity assessment for 'safety, care delivery and DoLS'. This does not follow the guidance where capacity assessments have to be decision-specific. In this instance the assessment followed the four key questions in the second part of the two stage capacity assessment and the person should have been deemed to have capacity. However, it was then recorded 'it is in [name's] best interests to have a motion sensor pad in place due to being at high risk of falls. While the decision to have the motion sensor was not wrong, there was no need for a best interest decision as the person had capacity and could decide for themselves. This meant that staff had not understood this important legislation.

Other mental capacity assessments were completed in conjunction with family members who may or may not have had the authority to give consent to any decision as there was no evidence of an appropriate lasting power of attorney obtained by the home. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment of people was not necessarily being provided with the consent of the relevant person as assessments were completed wrongly and checks about people's legal status were not made.

One staff member told us people's capacity was assessed "Before coming into the home by the GP, Care Home Liaison Team or whoever goes to assess them before admission. I've never assessed anyone and am not aware of the five principles." They continued "Even if people haven't the capacity to choose off the menu, we still offer them choice. We see what is on the menu and plate it up and show them. You get used to their likes and dislikes. Some people didn't want rhubarb crumble so they got offered yoghurt, rice pudding or ice-cream as an alternative." Another staff member repeated the same techniques of offering choice to people and prompting people where they lacked capacity such as for continence care. Although this meant staff were aware of the importance of offering people choices they did not fully understand how to support people within the guidelines of the MCA. The manager said links had been developed with the local authority lead to further develop understanding around this area as they realised it was poor.

We asked staff if anyone had their freedom restricted. One staff member told us "Doors are locked but people can still move around freely. If they want to go outside we will take them." When we asked what DoLS were in place for, they replied "It's safeguarding. They can't leave the building on their own. We have a couple on DoLS but I can't think of their names." This showed staff were not aware of how to support people effectively or had an understanding of any conditions that may apply to someone's DoLS. The manager had chased up DoLS applications which had been submitted some time ago and was waiting further information from the local authority.

We saw positional charts were used for people at risk of skin breakdown. In one record it said the person needed to be supported to re-position every two hours. This information was recorded at two hourly intervals. However, in another unit, although there were detailed records commencing 9 January 2017 no new charts had been added for the week commencing 16 January 2017. Four people in this unit were noted as needing pressure relief at two hourly intervals but there were no up to date positional charts in the floor management folder and we brought this to the manager's attention. This meant there was no evidence people had been receiving pressure care as required and staff had no idea what support had been offered previously.

We spoke with one member of staff about one person who we noted needed pressure relief. When we asked why they were not on a pressure cushion the staff member said "I don't think they should be on one" to quickly revise their statement to "They should be. It's normally on their chair." However, another staff member had a sound knowledge of who needed pressure care including the type of mattress they were using.

We saw notes of staff handovers which occurred three times a day. They detailed all key events for people and any specific information such as GP visits or whether they needed support with nutrition. Also recorded was basic information about how a person was moved if they required equipment, which medication was time specific and whether they had a motion sensor in place in their rooms. One relative told us "They arranged for a podiatrist and chiropodist for my relative" showing the home were responsive to changes in people's needs and acquired external support where necessary. We saw evidence in people's records of health and social care support.

We asked staff if they had received an induction when they first started and whether they received regular supervision sessions to discuss their practice developments and procedural changes. One staff member told us the induction lasted for two weeks and was detailed, covering all key aspects of care delivery. This had been followed by shadowing more experienced staff before undertaking work alone. Another staff member said they received supervision every five-six weeks and another was due this week. However, we did not find evidence of this. They also said they had had an appraisal last summer with the previous registered manager. This included discussions around their progress, if there was anything that needed further improvement and if the person had any concerns. The manager told us they were in the process of completing supervisions with all staff which had commenced at the beginning of the month and senior staff would be receiving training to take this forward.

Staff told us they received ongoing training and had regular refreshers, which were often online. However, they did stress moving and handling training was practical and had been delivered in another of the registered provider's homes. Staff had received training in understanding dementia, safeguarding, medication awareness (where applicable), equality and diversity, health and safety, fire food hygiene and infection control. One staff member told us how valuable they had found the dementia training as "it made me consider how people hear and see things differently."

We looked at training records and found some training had expired meaning staff may not have had the latest guidance. On 9 January 2017 we found two care staff had not renewed their safeguarding training, and a further nine had not renewed their moving and handling training some of which had expired in May 2016. This meant people were not being supported by staff who had received the necessary training to perform their jobs properly. This had been identified on a health and safety audit completed on 8 January 2017, along with other training gaps, and we saw the action noted for completion by 30 January 2017. We had confidence this would be remedied.

The environment was much improved since the last inspection as carpet and furniture had been replaced which had removed the malodour which had lingered and where air freshener had previously been used to disguise it.

Good

Is the service caring?

Our findings

One person said "There's a good choice of food here, you can have what you ask for" and another told us "I like the food." A further person said "If there's nothing I like on the menu, I can ask for something else and I'll get it."

Breakfast was flexible on time and choice, though one person was left waiting for some time as the carer had left the room and we had to ask the activities co-ordinator to get their meal which they happily and speedily did. Where people struggled to make choices, staff showed them different options such as a pot of jam to have on their toast. This showed a good awareness of how to support effective decision-making.

People had access to jugs of juice, crisps, chocolate bars and other snacks which were left on a side table and we saw drinks being offered on a regular basis throughout the day. Lunch was well organised and personalised with sufficient staff to meet need; it was freshly cooked and looked nourishing. If people were not keen on what was on offer, they were encouraged to ask what else they might like and alternatives were offered.

There was a high level of responsiveness and personalisation at lunch time though there was no visible menu and the condiments were in small individual plastic sachets which people couldn't open. One person was struggling with their appetite and fluid intake. They had not eaten breakfast and barely sipped any fluids although staff had provided both drinks and food. It was only at lunchtime when one carer focussed in a more concentrated way on their needs that they managed some liquid and a small amount of food.

Staff told us people who were nutritionally at risk were on food and fluid charts. One staff member told us about three people in one unit and we checked these people's nutritional records. They explained the records were analysed on a weekly basis by the care manager who would review if people were being supported effectively. We noted in some units file recording was variable with gaps in entries for meals and where short term care plans were in place for people, they did not provide guidance to staff as to how support people effectively.

We saw on more than one occasion reference to 'good diet' and we asked one staff member what this meant. They told us it meant five or six glasses of fluid or that the person had eaten all their meal. However, as people's portion sizes varied and it was no record of calorific content this was not an accurate way to record nutrition. They were aware one person responded better the less food was on their plate and would always offer them more if they finished this. We observed people being encouraged to eat in line with their nutritional care plan.

One person had been noted in their care record as having lost weight and was on a food and fluid chart. It was noted staff were to encourage high calorific food and the GP had been informed. Weekly weights were recorded and it was evident the person was putting weight on. There were two people who had had significant weight loss over a six month period but we saw the reasons for this noted and actions taken to try and limit further weight loss. This demonstrated weight monitoring measures were being followed

effectively.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found people had mental capacity assessments in their care records. However, these were not completed in line with the requirements of the legislation. In one record there was a mental capacity assessment for 'safety, care delivery and DoLS'. This does not follow the guidance where capacity assessments have to be decision-specific. In this instance the assessment followed the four key questions in the second part of the two stage capacity assessment and the person should have been deemed to have capacity. However, it was then recorded 'it is in [name's] best interests to have a motion sensor pad in place due to being at high risk of falls. While the decision to have the motion sensor was not wrong, there was no need for a best interest decision as the person had capacity and could decide for themselves. This meant that staff had not understood this important legislation.

Other mental capacity assessments were completed in conjunction with family members who may or may not have had the authority to give consent to any decision as there was no evidence of an appropriate lasting power of attorney obtained by the home. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) 2014 as care and treatment of people was not necessarily being provided with the consent of the relevant person as assessments were completed wrongly and checks about people's legal status were not made.

One staff member told us people's capacity was assessed "Before coming into the home by the GP, Care Home Liaison Team or whoever goes to assess them before admission. I've never assessed anyone and am not aware of the five principles." They continued "Even if people haven't the capacity to choose off the menu, we still offer them choice. We see what is on the menu and plate it up and show them. You get used to their likes and dislikes. Some people didn't want rhubarb crumble so they got offered yoghurt, rice pudding or ice-cream as an alternative." Another staff member repeated the same techniques of offering choice to people and prompting people where they lacked capacity such as for continence care. Although this meant staff were aware of the importance of offering people choices they did not fully understand how to support people within the guidelines of the MCA. The manager said links had been developed with the local authority lead to further develop understanding around this area as they realised it was poor.

We asked staff if anyone had their freedom restricted. One staff member told us "Doors are locked but people can still move around freely. If they want to go outside we will take them." When we asked what DoLS were in place for, they replied "It's safeguarding. They can't leave the building on their own. We have a couple on DoLS but I can't think of their names." This showed staff were not aware of how to support people effectively or had an understanding of any conditions that may apply to someone's DoLS. The manager had chased up DoLS applications which had been submitted some time ago and was waiting further information from the local authority.

We saw positional charts were used for people at risk of skin breakdown. In one record it said the person needed to be supported to re-position every two hours. This information was recorded at two hourly intervals. However, in another unit, although there were detailed records commencing 9 January 2017 no new charts had been added for the week commencing 16 January 2017. Four people in this unit were noted as needing pressure relief at two hourly intervals but there were no up to date positional charts in the floor management folder and we brought this to the manager's attention. This meant there was no evidence people had been receiving pressure care as required and staff had no idea what support had been offered previously.

We spoke with one member of staff about one person who we noted needed pressure relief. When we asked why they were not on a pressure cushion the staff member said "I don't think they should be on one" to quickly revise their statement to "They should be. It's normally on their chair." However, another staff member had a sound knowledge of who needed pressure care including the type of mattress they were using.

We saw notes of staff handovers which occurred three times a day. They detailed all key events for people and any specific information such as GP visits or whether they needed support with nutrition. Also recorded was basic information about how a person was moved if they required equipment, which medication was time specific and whether they had a motion sensor in place in their rooms. One relative told us "They arranged for a podiatrist and chiropodist for my relative" showing the home were responsive to changes in people's needs and acquired external support where necessary. We saw evidence in people's records of health and social care support.

We asked staff if they had received an induction when they first started and whether they received regular supervision sessions to discuss their practice developments and procedural changes. One staff member told us the induction lasted for two weeks and was detailed, covering all key aspects of care delivery. This had been followed by shadowing more experienced staff before undertaking work alone. Another staff member said they received supervision every five-six weeks and another was due this week. However, we did not find evidence of this. They also said they had had an appraisal last summer with the previous registered manager. This included discussions around their progress, if there was anything that needed further improvement and if the person had any concerns. The manager told us they were in the process of completing supervisions with all staff which had commenced at the beginning of the month and senior staff would be receiving training to take this forward.

Staff told us they received ongoing training and had regular refreshers, which were often online. However, they did stress moving and handling training was practical and had been delivered in another of the registered provider's homes. Staff had received training in understanding dementia, safeguarding, medication awareness (where applicable), equality and diversity, health and safety, fire food hygiene and infection control. One staff member told us how valuable they had found the dementia training as "it made me consider how people hear and see things differently."

We looked at training records and found some training had expired meaning staff may not have had the latest guidance. On 9 January 2017 we found two care staff had not renewed their safeguarding training, and a further nine had not renewed their moving and handling training some of which had expired in May 2016. This meant people were not being supported by staff who had received the necessary training to perform their jobs properly. This had been identified on a health and safety audit completed on 8 January 2017, along with other training gaps, and we saw the action noted for completion by 30 January 2017. We had confidence this would be remedied.

The environment was much improved since the last inspection as carpet and furniture had been replaced which had removed the malodour which had lingered and where air freshener had previously been used to disguise it.

Good

Is the service responsive?

Our findings

One relative told us "They put on a lovely Christmas lunch for us as relatives, and then a buffet and singer. We are made very welcome. I know about their care plan and how to look at it." Another relative said "They try to keep them all entertained, they make a real effort. They are lovely with my relation."

We observed the Activities Coordinator working well with people to promote interest and engagement and we saw them beginning to create a Chinese dragon as part of the future celebration of Chinese New Year. They told us they consider interactive ideas and events, making good use of the coffee shop/bar and the sweet shop, utilising the resources the home has. We also observed an exercise teacher who provides fortnightly classes to promote mobility and people were engaged in their class. People regularly had access to singers and musicians and events such as 'pop-up' restaurants, a Burns night celebration and Valentine's Day party were planned. Some people had recently been to the theatre to see 'Strictly Ballroom'.

We also observed staff in the upstairs dementia unit undertaking direct focused work with people focusing on memories. They were working through a book which had relevant images centred on decades; another staff member used scrabble to help spell out names. One staff member said "Activities are offered on both floors. People can do flower arranging or stain glass. [Name] likes to watch sport and join in everything." People seemed to be responding well and were encouraged to join in. We noted on the second day no one came out of their room on the residential unit downstairs. When we asked why staff told us people preferred to watch their own TV or do knitting and we observed this happening.

We looked at care records and found they were detailed. The records included short term care plans where people had an acute infection or some other temporary impairment. These detailed what action had been taken, such as a GP visit, and actions to follow as a result. People's life histories were completed in depth to enable staff to support them effectively, especially where memory loss was evident as these details provided key information about people and events important to that individual and helped promote relationship building.

Care records were written in a person-centred manner. In one record we saw noted "I can wash my hands and face but find the rest of my body too hard to reach. I want to try to be as independent as possible so I want to be involved in my care as much as possible."

Carers were responsible for completing daily notes which we saw were done in detail during each shift. They noted the person's mood and activities as well as specific support with tasks. Where people had celebrated a special occasion this was also noted along with who had visited. In one record it was noted "[Name] has celebrated their birthday today. Their [name] has been enjoying opening presents with them. They have been in a lovely mood." If people chose their own clothes this was also noted, again evidencing choice being offered. If something significant had happened, it was logged what action had been taken such as a referral to the falls clinic if this had become an issue.

We asked staff how they got to know someone. One staff member told us "We get to know them and read

their care plan. We ask them what's important to them such as their family." Each care record had many care plans which were reassessed on a monthly basis and amended accordingly, although we found sometimes the information was too detailed to identify the key issued quickly. The impact of having dementia was noted where relevant in relation to how it affected the person. One record indicated the person would continually ask for their relative and showed staff how to offer support and reassurance. It wasn't always evident how much involvement people had had in the writing of their care plan where they were able.

The home had not received any complaints over the past three months although people did express low level concerns about clothes going missing. One person said "It's alright, they do their best, I suppose. All your clothes get mixed up, there's always something missing, I don't like it." We asked staff how they would deal with any complaints. One staff member said "It depends whether I could deal with it myself. Laundry or clothes I would sort out myself. Other complaints would go to the manager." We were not able to assess the ability of the home to address such concerns as they were not recorded.

The people and relatives with whom we spoke all expressed high levels of satisfaction with the care received. Relatives were equally happy with the way they were involved in the planning and receiving of information about progress or other issues. We saw a compliment received from the Mayor of Kirklees following their visit in November 2016 where they commended the home for its level of activity. This was displayed on each of the unit's walls for all to see.

Requires Improvement

Is the service well-led?

Our findings

We asked people if they liked living at Ashworth Grange. One person said "It's very nice and I have a lovely room. It's just like a hotel." Another told us "I think it's a lovely place, very nice indeed." Relatives were equally complimentary. One relative said "For [name] it is brilliant. They are very happy here" and another told us "I think it's fine and well run here. It works for [name]." A further relative was keen to emphasise the improvements "The home is in transition and has been for many months. Staff have been coming and going, though the staffing levels are now spot on and they are either excellent or very good. They go out of their way and even come in when off duty to help with and attend events. The new manager is very enthusiastic, friendly, open and approachable. They have an open door and are willing to listen. The atmosphere is good and well balanced."

Although we found continuing issues with medication and the inaccurate application of the Mental Capacity Act 2005, we saw in all other areas significant improvements had been made despite the manager only having been in post for two months. They had tackled many issues and we had confidence this would continue to improve. Following the inspection they had shared with us an action plan for immediate changes to medication and accepted the issues we had raised. This showed they were responsive and keen to ensure best practice.

We saw evidence of resident and relatives' meetings for July 2016 which asked people what improvements could be made, whether they wanted any amendments to the menu and were they happy with the activities. The response was all were happy with the care and felt they were treated with dignity. There was also discussion around the previous inspection findings. The meeting also included discussion around proposed trips to a garden centre, ice-cream parlour, fish and chip restaurant and some local tea rooms which we saw had taken place. At a further meeting in October 2016 discussion included the new manager's impending arrival, the refurbishment and the recruitment of new staff. All of these points were explained and progress shared with attendees.

We asked staff how they felt working in the home. One staff member said "Team members are really supportive." Another said "The staff are lovely and it's homely." They said things had been changing a lot recently and they had found this hard to keep track of. However, they realised it was needed as staff needed to share more responsibility and take ownership of their tasks.

We asked staff if learning was shared about specific incidents such as falls or safeguarding concerns in the home. One told us "We are told and try to make sure it doesn't happen again. There has been nothing recent." We saw staff meetings were held regularly. The one held in September provided in-depth feedback about the inspection in June, discussion around the importance of respecting dignity and ensuring effective communication through the timelines of shift handovers and also about staff conduct as some staff had been noted to 'disappear' while on shift without any communication with their colleagues.

A further staff meeting held in October 2016 relayed information to staff about call bell response times and the importance of ensuring these were responded to promptly. Staff commented on the difficulties of swift

responses if they were in the middle of transferring someone as this required two staff. It was noted staffing ratios had increased as a result to eleven carers per day (two of which were seniors) and five per night. We also noted staff discussing people's dependency levels and the area manager informed them of a new dependency tool being implemented. We saw this was being actioned from January.

We asked staff what they felt the values of the home were. One told us "to promote dignity and respect along with independence. Sometimes a person may ask for help but you know they can do it so I say 'You can do it. I'll stand here while you do it'." The manager said "I want to promote a 'home from home' feeling, in a friendly and loving atmosphere. I know staff already go the extra mile by picking up bits of shopping."

Staff felt supported. They told us they could approach either the home manager or care manager. One staff member said "I see a big difference with the new manager. They are more approachable and more for the people in the home. [Name of new manager] is more about the people in the home and what's best for them." They were strongly supportive of the changes that had already been made saying "I can see the difference in everything. I feel more included in everything. We are no longer kept in the dark." Another said they were equally happy to discuss any concerns and would not be fearful of doing so.

Staff also said they frequently saw the area managers and the registered provider who visited the home. The regional managers had changed three times over the past year and the current one just came into their post on the first day of inspection. However, we did see there had been an oversight from all the previous senior managers which was relayed to staff in meetings. Action points were agreed for completion by the registered manager including how to complete more effective audits and organise staffing better. These reflected issues raised by the previous inspection and reinforced the importance of following through specific concerns to a resolution.

The home had been working through a service improvement plan and it was clear some actions had been followed very closely such as improvements to care plan records and discussing the purpose of certain documentation, for example falls. However, other areas regarding the assessment of mental capacity was not completed correctly identifying further training needs and the auditing of medication was not effective given the concerns we found. Following the completion of the inspection the manager did send an action plan relating to some of the issues with medication showing they had taken these concerns seriously and were keen to effect change quickly.

One staff member said "I love working here. I love helping and I love the residents, knowing I can make a difference to people's lives." Another staff member told us "There have been a lot of changes recently but they're all for the better." They explained "Paperwork is a lot better as are the handovers. I can now see how things link together such as if a person has an accident."

The manger had been in post since November 2016 and was in the process of applying for registration. They told us they had been involved in significant changes in relation to staffing and performance issues and this had resulted in a change to key personnel. Their focus had been on acquiring the right staff to improve morale in the home and enable the staff to receive training to enable them to perform their jobs with confidence and accuracy. They had worked hard on getting staff to feel supported by making themselves accessible and visible, and a number of staff commented to us on this. This was evident during the inspection.

The manager had re-developed the system of a keyworker for the person so families knew who to approach initially with any concerns. One staff member told us about these changes and how they were getting a list of all the elements the keyworker role would bring such as ensuring a person's room was tidy and they had

enough personal effects. The manager told us the intention was for eventually care staff to be supervised monthly by seniors who would receive training in this area and they were in the process of implementing this change.

One of their initiatives had been 'dining with dignity' where senior staff supported care staff at mealtimes to ensure the experience was positive and pleasant for people. The manager shared working at weekends with their care manager so staff had seven day support which was helping reduce sickness levels as staff felt acknowledged and had effective advice available.

The manager had ambitious plans for further development of the home environment. This included the creation of a flower shop and post office. They told us there would be a mix of real and artificial flowers for people to choose each day, and every Wednesday people would be able to access a flower arranging class. We asked the manager how they ensured staff were delivering good practice. They said "I am hands on and spend time on the floor, will mentor people and focus on their key qualities. I will lead by example."

Audits had developed into more effective tools and we saw monthly analysis of key information such as falls, weights, safeguarding concerns, complaints, bed rails checks, pressure sores and medication. Evidence of action taken was noted such as referrals to the tissue viability nurse, dietician or GP and the guidance from these was also recorded. Equipment such as soiled mattresses had also been replaced. It was clear from looking at the audits for the preceding six months some of these changes had been effective as incidents had reduced and people's health had improved.

There were also thorough audits for infection control, catering and housekeeping. Again, evidence of improvement was seen as furnishing had been replaced, further equipment bought for the dining rooms and staff retrained where necessary. The audits, while providing an overview of the home's performance, were also detailed enough to track people's progress in relation to specific issues such as pressure sores or weight loss, and this meant any necessary interventions could be arranged more promptly.

The manager had instigated weekly 'head of department' meetings and we saw evidence of this leading up to Christmas. Key issues around health and safety were discussed including falls, accidents, infection control, food and fluid intake for people at risk and equipment cleanliness. This provided a mechanism for progress to be monitored and any issues raised to have remedial action taken.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Assessments for mental capacity were generic, being completed for people who had capacity and did not evidence whether the person who had signed it had the authority to do so.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not safe due to multiple concerns around medication administration and storage. There was no evidence the home had assessed people appropriately for moving and handling equipment, and staff did not have the necessary guidance to follow.

The enforcement action we took:

Warning notice