The Orders Of St. John Care Trust

Ashwood Care Centre

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Ashwood Care Centre is a purpose built home that provides accommodation and personal care for up to 82 people. At the time of our visit, 76 people were using the service. The inspection took place on 25 and 26 April 2017. This was an unannounced inspection. The home was last inspected on 23 March 2016 and received a rating of Requires Improvement.

The home was rated as Requires Improvement at this inspection but action had been taken to improve and three of the previous breaches of Regulation had now been met. The home had remained in breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post when we inspected the service. 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 registered manager was accessible and approachable throughout our inspection. Staff, relatives and people who used the service told us the registered manager was available if they needed to speak with her and had confidence in her abilities to manage the service.

Although staff responded well in supporting people with behaviours that challenged, the appropriate guidance and risk assessments were not always in place to manage this. For example one person's emotional wellbeing care plan stated they would "Pick up objects and threaten staff and residents with them, was verbally aggressive and would hit or punch." There was no risk assessment in place that covered these particular behaviour expressions in order for staff to assess and review that the person was being supported in the most appropriate way.

Mental capacity assessments were not always consistently recorded and followed. Where people had someone to make decisions and consent on their behalf, this had not been correctly documented in care records. The service had not completed the required actions needed to meet the breach identified at the previous inspection and remained in breach.

We observed at this inspection that the home was not displaying the ratings from the last inspection. A report was available in the reception area but this was not in clear view and was behind some other brochures. The registered manager took swift action to ensure this was reinstated during the inspection.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home, however some of the issues we had identified during our inspection had not been picked up, including risk assessments and management around behaviour management and mental capacity assessments.

Medicine management had improved since our last inspection and the service were no longer in breach of safe practice in this area.

People told us they felt safe. Staff had received safeguarding training, and were aware of their responsibilities in reporting concerns, and the concerns of those they supported.

People received care and support from staff who had got to know them well. Staff were able to tell us about people's likes, dislikes and preferences. Staff told us it was important to find out about people and aid conversations and building important relationships with people. People said they were cared for by friendly staff who kind, helpful and supportive. Comments included "The staff are fantastic here, they really care."

People felt confident to raise any concerns they had and felt they would be responded to in a timely manner. Copies of the complaints procedure was clearly displayed and contained information on how to complain and where to go if you felt the complaint was not resolved.

People and their relatives spoke positively about the leadership of the home commenting "I do speak to her, she is a cracker, she is intelligent, very clever, I have the upmost respect for her" and "I know the manager, I think she is doing a terrific job." Staff told us they felt well supported by the registered manager who was approachable and listened to their views.

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 mostly safe.

Although staff responded well in supporting people with behaviours that challenged, the appropriate guidance and risk assessments were not always in place to manage this.

There were mixed reviews in regard to levels of staffing and laundry staff were struggling to address the large amounts of washing in the hours provided.

Medicine management had improved since our last inspection and the service were no longer in breach of safe practice in this area.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments were not always consistently recorded and followed. Where people had someone to make decisions and consent on their behalf, this had not been correctly documented in care records. The service had not completed the required actions needed to meet the breach identified at the previous inspection and remained in breach.

There were arrangements in place to ensure staff received regular supervision and appraisals.

People were supported to maintain good health and had access to appropriate services which ensured people received on-going healthcare support.

Is the service caring?

Good

The service was caring.

Staff were genuinely passionate about their role in the home. Staff knew people well and were aware of people's preferences for the way their care should be delivered.

People and family members we spoke with gave us very positive

feedback about their care workers and told us they were caring.

Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

Is the service responsive?

Good

The service was responsive.

People were supported to make their views known about their care and support. People were involved in planning and reviewing their care plan.

Activities were offered that enabled people to spend time with others and maintain and develop links within the community.

There was a system in place to manage complaints and comments. People were confident that any complaints they made would receive an appropriate response.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

We observed at this inspection that the home was not displaying the ratings from the last inspection.

Quality assurance systems were in place, however some of the issues we had identified during our inspection had not been picked up.

Staff said they felt well supported by the registered manager who was approachable and listened to their views.

People spoke highly of the management and were kept informed of events relating to the home.

Ashwood Care Centre

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 25 and 26 April 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacist from CQC medicines team and two experts by experiences. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The home was last inspected on 23 March 2016 and received a rating of Requires Improvement.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 27 people living at the home, 14 relatives, two volunteers, four health professionals, 15 staff members, the deputy manager, area operational manager and the registered manager. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for 22 people, medicine administration records (MAR), six staff files, the provider's policies and a selection of the services other records relating to the management of the home.

We observed care and support in the communal lounges and dining areas during the day and spoke with people in their bedroom. We spent time observing people's experiences at lunch time and observed the administering of medicines.

Requires Improvement

Is the service safe?

Our findings

Some people living in the home had specific health conditions that at times would cause them to become anxious or express themselves in physical or verbally aggressive ways. We saw that the appropriate documentation to manage these situations was not always in place for staff to follow. For example one person's emotional wellbeing care plan stated they would "Pick up objects and threaten staff and residents with them, was verbally aggressive and would hit or punch." There was no risk assessment in place that covered these particular behaviour expressions in order for staff to assess and review that the person was being supported in the most appropriate way.

Another person's daily notes recorded entries such as "Trying to punch carers", "Grabbing and pinching carers and also kicking out", "Became violent, kicked carer several times and hitting out lots", "Very aggressive towards carer." The mental health care plan documented medicine the person had been prescribed to ease their anxiety, but did not record other methods for staff to try before administering medicine. We did see some examples of clear recording guidance where staff were informed to give a person space, talk to them about when they had previously worked, offer a cup of tea or go for a walk in the garden. However there was no separate risk assessments for these types of behaviours in place.

The provider's policy on "Dealing with violence and aggression" stated that "All employees should be trained to recognise the early warning signs of aggression and to respond to calls for assistance. Employees should try to de-escalate incidents." Staff had attended distress reaction workshops which looked at triggers for behaviour and how to support with behaviour management; however they had not received further training in managing episodes of violence and aggression which may result in a need for more enhanced techniques and knowledge. The policy further said that "A risk assessment must be completed to determine the level of risk of incident reoccurring." This was not in place at the time of our inspection. The registered manager told us that behaviour risk assessments would be put in place without delay and that she would raise again with senior management about staff training.

We observed staff in practice responding to emotionally charged incidents or where people were anxious and saw they managed these well. Staff took time to reassure people and demonstrated kindness, compassion and patience in their approach. One person was worried that she could not return to her room as the carpets were being shampooed and staff took time to sit with this person, listen and explain the situation. Another person who was quite distressed would regularly approach staff repeating the same question. On each occasion staff gave the person time, reassured through gentle touch, brought the person a drink and snack and sat with them until they were calm again. One staff member told us "We are aware of the causes of challenging behaviour, pain, frustration, loud noises and pressure. We would try and calm the person, try and distract them. If that didn't work we would walk away and come back and take advice from our dementia lead." This meant that although the correct documentation was not in place staff understood how to manage and respond appropriately to people in these situations.

Some people were at high risk of developing pressure areas and were using pressure relief mattresses. We found there was no system in place to monitor the setting of the mattresses. Staff told us the setting was

recorded on the repositioning chart, however not all people who were on pressure relief mattresses were on a repositioning chart. We saw that the setting had not been recorded and instead it only stated if the person was on an air mattress. Senior management explained that if there was a problem with the air mattress, an alarm would go off. We questioned what would happen if an alarm did not go off, how would staff know that the person was not on the right setting. Senior management told us they would action this immediately to ensure staff checked daily.

We found that assistive equipment to help people mobilise was often left in communal bathrooms compromising the accessibility. For example we observed a pressure mat, wheelchairs and stand aids in various bathrooms around the home. One staff told us there was not always room to keep them in the designated cupboards. We saw that hoist and laundry cupboards had key code access to restrict entry and keep people safe; however these were frequently left open. We asked staff why this was and they told us they should always be locked, it was just a case of some staff not always taking the time to shut them properly.

Staff carried buzzers on them which alerted them when a person pressed their call bell and needed support. We saw for one person who did not have capacity to use their call bell staff completed half hourly observations for this person when they were in their room to ensure they were safe. These checks had been recorded on a monitoring form. When people experienced a fall, they were monitored on an observation chart up to 72 hours after the accident. We checked one observation chart and found dates and times were not recorded correctly. During a check a staff member recorded the person said they were in pain. There was no evidence of action taken by the staff member or any pain relief offered. We also found the person's falls risk assessment had not been updated. We cross checked this person's daily record and also found no evidence of any action taken. For another person who had experienced several falls in a short space of time, tests had been completed to rule out other medical causes. The GP had been involved and prescribed medicine and the safeguarding team had been contacted about the falls and their responses clearly recorded.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. For example when a person had a choking incident, learning was identified to ensure the incident did not reoccur. Staff were made aware to check for any changes in the person's speech and language and to make a referral to SaLT if needed (SaLT)provides assessment of swallowing or communication difficulties for people). Another example was where a person had a fall and sustained an injury. Actions taken were recorded and checks made to minimise the risk of the incident reoccurring, for example checking the person's foot wear and ensuring no trip hazards were identified. Staff told us they knew what procedure to follow when people had accidents and incidents.

The home had changed its registration since our last inspection and was no longer providing nursing care or employing nurses. This decision had been taken after a struggle in recruiting and maintaining nursing staff. The home now had a dementia lead in place responsible for overseeing the ground floor and the deputy manager oversaw the first and second floors. They were then also supported by seniors on the floor. At the time of our inspection the registered manager was recruiting for some vacant hours across the different positions within the home including maintenance, care, kitchen and laundry staff. The registered manager told us she was also thinking ahead to recruit into maternity and long term sickness posts to keep consistency.

We received mixed reviews in regard to the staffing levels but during our inspection we saw that staff were visible on the units and people did not have to wait long before receiving support. People told us "No I don't think there are enough staff, during the day it seems very difficult to keep the staff", "No they don't have enough staff, they keep coming and going. They have a huge turnover of staff", "Sometimes they seem short

staffed, I think they could do with more staff. If one goes off sick then they are in trouble", "There seems like there is always someone there. You ring the bell and they always come", "I have a call bell in my room and when I use it they come quickly" and "I have a call bell around my neck and they come very quickly, especially at night." People's relatives commented "I think they could do with more staff, sometimes it's worse than others", "I think they need more staff there just doesn't seem enough", "There is plenty of staff. He gets the help he needs" and "Staff help straight away." One health professional commented "Staff are very caring; they have sufficient numbers of staff per residents."

We spoke with staff who told us although staffing had at times been stretched it was generally manageable commenting "Recently we haven't had enough as two staff are on the sick, but now it's more steady, we have a good team. There is time to sit with people or pick up jobs so other staff can make time with their key person", "Staffing varies, mostly it's ok but we do get days when people are off but we get through it. There is no agency, we pick up the extra shifts. We get time to spend with people take them outside, one person likes going to town", "We get a few blips but it's fine, we work it out together, we have time to talk with people" and "There could be more staff, it can be stressful as trying to support people. The support from seniors is good." An assessment tool was in place which looked at the levels of people's needs across areas including manual handling, personal care and communication to help determine the hours of staffing required. The registered manager told us that this tool was being looked at again as it calculated the home was overstaffed but did not account for the layout of the building which was across three floors and six separate units and had an impact on the way staff were deployed. The registered manager told us "We will work one staff short but if we need agency we will have it. March was tight with people getting their holidays in and have got some on long term sick. We are looking to cover peak times with short shifts and an extra weekend carer."

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults.

We found the home to be clean and tidy, however during the two days of our inspection there was a strong smell of urine in two areas. We raised this with the registered manager who was aware and saw that staff were taking steps to address this and keep clean. During our inspection it was brought to our attention that staff did not feel there was enough bedding in the home. We observed one person lying on a blanket with no sheets on their bed and staff told us this was because of a shortage and they were waiting for sheets to come out of the wash. One staff said "We did not have a sheet this morning for the person to put back on their bed after an incontinence episode. Downstairs use a lot of sheets so we do run out." Another staff said "We do run out of sheets and have to run around the building to find one and if not we pass it over in handover". Staff also told us that there was not enough hours for them to manage the laundry safely. Night staff were no longer able to do laundry during the night, which meant all laundry that had not been finished by 6pm was left until the morning, which accrued with the night time laundry. This meant soiled laundry were left for long periods which could be an infection control risk. The registered manager said that because the home was part of a neighbourhood they were not able to continue with washing after this time due to the noise impact. It had already been identified that more hours were needed in laundry and this was being currently managed.

Staff knew what procedures to follow during an outbreak of an infection including wearing personal protective equipment such as gloves and aprons, using the appropriate cleaning materials and making sure that trolleys and cleaning equipment remained in a specific area. Hand sanitising gels were placed at strategic points throughout the home and washing stations were well stocked.

At our last inspection in March 2016 the service was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines had not always been managed safely. An action plan was provided by the home which stated that measures would be put in place to address this which included monthly medication audits. We followed up the issues that were identified at the previous inspection in March 2016 and found that these had been addressed and medicines were now safely managed in the service.

We reviewed the Medication Administration Record (MAR) charts for 31 people and the care plans relating to medicines for ten people. We found that the MAR charts had been completed in accordance with the policy of the provider. Where people had medicines prescribed to be taken "When required" (PRN) we found that there was sufficient information to support staff in making a decision about when the medicine was needed, what actions should be taken before administering and what the expected outcome should be. One person had chosen to self-administer their medicine and we saw the GP had signed in agreement with this. A medication disclaimer was in place signed by person and a risk assessment had been completed.

We found that where people were prescribed variable doses of medicine that the actual amount of medicine given was recorded. We did find for one person that this had not happened although staff told us that this person had the same dose of medicine on each occasion. The supporting information with the record was amended during the inspection. We found that medicines were stored securely and within the appropriate temperature ranges and the service took action to monitor this. We saw that revised expiry dates were recorded on products where the manufacturer's original date was changed either by opening the product or storing at a different temperature. We did find that on three occasions the revised date had been incorrectly recorded but this was amended during the inspection and the medicines were still within the amended expiry date. We observed part of four "Medicine rounds" and saw that staff administered medicines to people safely. Staff explained to the person what each medicine was for, gently prompted them to swallow the medicine without rushing them. Staff then signed the MAR chart to show that the person had taken the medicine, or if they did not take the medicine made a record of what had happened.

We saw that one person was receiving their medicines in a covert manner. This meant that the person was not aware that they were taking the medicine as it was disguised in either food or drink. We saw evidence in place that this was only being done in accordance with the decision of a "Best Interests" meeting in accordance with the Mental Capacity Act 2005. A signature was recorded from a GP to document they had agreed to this medicine being given in a covert form. It did not however state on the printed MAR that this could be given covertly. The registered manager took immediate action to source this by faxing the surgery so the correct authorisation could be in place on the person's MAR. One health and social professional told us "They are very conversant with legislation and its implications. They do not take decisions such as covert medication lightly and it is rarely used as they are normally able to use their knowledge of the resident and their skills to get compliance through good care and team work."

People we spoke with told us they felt safe living at Ashwood commenting "A nice safe place to live, staff look after us well", "Yes I feel safe, the fact is there is always someone around and they are all so very friendly", "Yes to an extent I do. There are always people here. And I think the security is good", "Yes I feel safe, it's the staff, they are very good and respectful", "I feel safe at night. I know they look in on me. I hear the door creak open. They peep in but I pretend to be asleep" and "Yes I feel safe here, I am never alone in here." One relative told us "Yes she is safe; there is always someone here when she is wondering about." Another relative said 'Mum is content and safe, a great thing for us."

Staff had received safeguarding training, and were aware of their responsibilities in reporting concerns, and the concerns of those they supported. Staff told us "It's about making sure every individual is protected and

has person centred care. I have had training. I wouldn't hesitate to report to the manager and record. We look for changes in behaviour, if they seem depressed or out of character and body map anything", "I would report anything to the senior or go up to the management. At the end of the day I'm here caring for people" and "If I saw or suspected abuse I would report it immediately to the manager. If the manager was unavailable I would report it to safeguarding, even escalate it to the police."

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2016 the service was found to be in breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because consent to care had not always being sought in line with legislation and mental capacity assessments had not always been fully completed. An action plan was provided by the home which stated they would address this without delay. At this inspection we found that the service had not taken the required actions needed to meet this Regulation and remained in breach.

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. The registered manager had made applications for DoLS authorisations as required. Applications had been submitted to the Local Authority Supervisory body for which some were still awaiting a response and some applications had been authorised. People were receiving care and treatment in the least restrictive way and could move freely around the building. People were also able to access the garden areas when they wished to do so. One person told us "There are no restrictions as to when my family can come and go, and none for where I can go inside or outside the home."

We found that where conditions on authorisations were in place, the conditions were not always consistently met and recorded. For example for one person we saw evidence of consulting with the person's family as per condition to contact the daughter monthly with an update on the person's care. Conversations with the daughter were clearly recorded. However, for another person we found no record of conversations with the person's representative as per DoLS condition.

Where people lacked the mental capacity to make specific decisions, we found necessary mental capacity assessments had been completed. However there was no evidence on the mental capacity assessments of who was consulted, what the discussions had been and how the decision was made in the person's best interest. For example where a decision had to be made for a person to have a sensor in their room to alert staff when they were mobilising, there was no evidence that the family had been consulted. For another person a mental capacity assessment was in place for consent to receiving daily care and treatment at Ashwood Care Centre for the purposes of a DoLS application. Again there was no record of who was consulted or any information on discussions which led to the best interest decision. Senior management told us a document was going to be put in place throughout the provider's homes which gave staff guidance on how to on how to correctly complete these assessments.

Speaking with staff they showed a good understanding of the principles of the MCA and what it meant when a person lacked capacity to make a decision. Comments included "You must never presume they don't have capacity. Give people choices and support as much as you can to make a decision" "It's about protecting residents rights, we have a little book of the MCA that we keep on us as a reminder", "When someone has capacity to make a decision, it's not about whether we think it's a wrong or right decision. We do things in their best interests we talk to GP's, social workers and their family" and "Some people struggle to make decisions but they can still make some small decisions. We always offer choice and assume they have capacity." We observed staff seeking people's consent before supporting them. One person was only helped when they gave consent to being assisted into a wheelchair. On one occasion a person refused help and wanted to remain in their room. Staff accepted this decision and a member of staff returned later. This time the person said that they wanted help to get to dinner.

Some people had given others lasting power of attorney (LPA) in relation to either their finances or their care and welfare. This gave them the power to take decisions on behalf of the person if they lacked mental capacity. The service had obtained details of LPAs where people had them; however this was not consistently recorded in people's care records. Some care plans stated a person had LPA for health and welfare, however when we checked the providers records, the person only had a LPA for finances. This meant staff were not consistently aware of who to consult when making specific decisions about people's care and treatment. The registered manager had sent letters out to relatives asking them about the status of their LPA. Plans were in place to create a care plan so team leaders were clear about who had LPA in place and what decisions each particular LPA authorised people to make. We found that GP's discussed with people where necessary about their wishes on being resuscitated in the event that they stopped breathing. For people who lacked capacity to make a decision about resuscitation, we found that 'Do Not Attempt Resuscitation' forms were not consistently completed showing that a consultation with the appropriate representative had taken place. This had not been picked up through care plan auditing in order to raise with the GP so action could be taken to ensure this was appropriately completed by the GP.

This was a breach of Regulation 11 (1) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in March 2016 the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not been supported to attend regular supervisions and training necessary to their role. An action plan was provided to detail how the home would take steps to address these concerns. At this inspection we found the home had made enough improvements to no longer be in breach of this regulation.

Staff told us they received regular training to give them the skills to meet people's needs commenting "I have done moving and handling, Mental Capacity, fire and most training is face to face" and "We have regular training, it's very good here. I speak to the manager and ask for training". Several staff said that they were either doing or about to do a National Vocational Qualifications (NVQs) and further develop their skills. Staff had a good understanding of Dementia. They had undertaken basic Dementia awareness training and some had attended a course designed to enable staff to experience the reality of the condition. A Dementia lead had also been appointed to oversee training and provide additional support and advice to staff.

We saw that staff had received some training in behaviour management and senior management were working to source further more in-depth training. The registered manager told us that their dementia training covered the communication aspect of managing behaviours that could challenge but not the physical nature of these behaviours. The area operations manager explained that steps were being taken to address this and that she had attended some training with the admiral nurses (Specialist dementia nurses)

on safe holding, but this had not been right for the trust. Following this a teleconference had been held to debate about bespoke training being sourced for this area. The registered manager told us that where they had an identified need of further support they worked closely with the admiral nurse and had close links with the care home liaison team. The registered manager had also been able to source some distress reaction training to further support staff in the interim period. One health professional told us "All the residents are given so much care and respect in all manner of situations. In my opinion the residents with mental health problems are all helped in a lovely and caring manner and they take the time to talk to them and help in any manner that the situation requires."

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included "Staff are very competent and extremely good" and "Staff are spot on and well trained". One staff member said "The team are diverse with fresh ideas and experienced ideas." Another staff said "We have a young team, but they are very conscious of how important their role is with the residents. We support our residents and each other, the residents are our family". Health and social care professionals commented "Staff are very approachable and always keen to help and do best for their residents", "The residents all get good care whatever their situation and the training is given and adhered to at all times" and "The Order of St John to my knowledge ensure that their staff are kept abreast of changes within the industry of care and are appropriately trained. New staff shadow a senior so they become aware of the customer's and their needs. I have witnessed staff training during my visits".

New starters had a probationary period of training and shadowing another member of staff. Staff told us "At my induction interview we had a walk around and then I was assigned a senior to shadow and reviewed things" and "We spent time going through things, manual handling, the policies, I did my care certificate, I am now a mentor and staff will shadow me." A senior staff member said "I am still learning and I like to share my learning with other staff." We saw that new staff received an induction walkabout and a checklist was completed to show they had been given relevant information about the home including the fire procedures. Staff said they received good support and had regular one to ones with their line manager and were also able to raise concerns outside of the formal supervision process. Staff comments included "I have supervision with the shift lead, and am able to raise anything. We can have one when we need as well", "Supervisions are regular, they are quite good", "I had opportunities to discuss professional development, but also staff rotas and flexibility around working hours" and "I had a recent supervision and it was positive. It was a two way session." We saw a supervision matrix displayed on the noticeboard which enabled the registered manager to track the progress of all staff supervisions and ensure that staff received these within the Trust's timeframes.

At our last inspection in March 2016 the service was found to be in breach of Regulation 14 Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because although risks in relation to nutrition and hydration had been identified the appropriate action had not always been taken. An action plan was provided to detail how the home would take steps to address these concerns. At this inspection we found the home had made enough improvements to no longer be in breach of this regulation. We observed mealtime experience for people across the different floors and saw that people were supported to have a meal of their choice. A lighter meal was served at lunchtime and a cooked meal in the evening. This was because the home had found people tended to eat more later in the evening, rather than a large cooked lunch not long after having breakfast.

We saw two examples where the mealtimes were not a positive experience. One person had fallen asleep in front of their meal at the table. Staff did not assist this person until 1pm; however everyone else had been eating their meal prior to this time and had moved onto pudding. The staff member that started to assist kept getting up to do other things and then returned again to put another mouthful of food into the person's

mouth before leaving again without informing this person what they were doing. Half way through, the staff swapped and another staff member came and stood over the person whilst putting another mouthful of food into their mouth. This staff member also then walked away. Throughout this interaction staff did not have the time to sit with this person and offer their meal in a dignified manner. Another person was observed eating their rice pudding with their fingers for five minutes until staff noticed and put a spoon into the person's hand.

One person did not like to sit for long periods of time to eat their meal. We saw in their care plan it documented this person was at high risk of malnutrition and needed support from staff around this. It recorded that this person would accept finger foods that they could eat whilst walking. The home had taken steps to support this person ensuring they were regularly weighed, involving the GP and giving supplement drinks and a fortified diet. We observed this person during one mealtime and saw they attempted to get up throughout. The person walked off after eating very little and one staff member said "She's had enough." We saw that sandwiches were available; however staff did not offer the person one of these to eat as they walked. The person then proceeded to walk right up to people whilst they were eating holding herself in an intimate manner. Three members of staff were present, some eating their lunch with people but made no attempt to intervene. One person said "Look" and pointed at the person and a staff replied "I'm watching her". It was not until the person tried to squeeze behind another person's chair did a staff member guide her away from the tables. We raised our concerns with the registered manager to address with staff.

All other observations we saw were positive. People were supported to have a meal of their choice and encouraged with drinks and snacks during the day which were also available around the home. We saw other staff interacting well with people during mealtimes, sitting with them chatting and checking they had enough. Where people requested something other than what was on the menu this was immediately adhered too. Staff showed people "Tester plates" of what dishes were on the menu that day and to enable them to make a choice. We saw that for people who needed monitoring with their food and fluid intake a chart had been put in place. Staff were given guidance on how to complete these assessments correctly. We saw that completed charts were checked and signed by senior staff and circled if the person's fluid intake had not been met so the appropriate action could be taken without delay.

People spoke mostly positively of the food commenting "The food is very good, like home cooking. We get a good choice but I don't have a favourite meal, and I never get hungry at night and I can always go and make myself a cup of tea in the kitchen area", "Love the food and oh the cakes they are wonderful", "It's average, it's alright if I eat it. And I get a good choice and never get hungry, at night I have a bar of chocolate and a scotch before I go to bed", "It's not bad, the quality is not that good and could be better, we get a good choice, two or three main courses sometimes and if you don't like what's on the menu they can cook you something else. My favourite meal is cottage pie, we get that twice a week", "They make you a hot drink anytime" and "I find it very good. I don't eat meat and there is always a good choice of menu. There is always a member of staff that eats with us. My favourite meal is fish and chips." One relative told us "They weigh [X] regularly, always been slender. Enjoys her food, quite happy. She has raided the fridge at 5am in the morning and there are plenty of snacks at night." We noted that during "Resident's reviews" some people had stated the choice of food did not always appeal to them and would like some choices weekly rather than monthly. We saw there was nothing recorded in the actions from the review, which meant the chef might not have been updated about these views and preferences.

People had access to health and social care professionals. We saw that where people had a specific health condition an acute care plan had been put in place. One person had a pain care plan in place and were not able to verbally communicate if they experienced pain. Physical signs were recorded for staff to look for so they could ensure this person received pain relief in a timely manner. One person said "The staff are very

good, they keep an eye on you if you're feeling poorly and get the GP if needs be." Another person told us "I can get to see the GP if needs be, and the staff try to understand you and they do encourage you to get up and they do seem to appear sympathetic."

We spoke with health and social care professionals who visited the home and they commented "Staff always take a multi-disciplinary approach involving, District nurses, Chiropody, Audiology optician, Admiral Nurse and Mental health to name but a few, as well as resident and their family where possible, "I have in the past had a patient who needed antibiotics, they acted in response to my advice without fail to get a doctor in to see the patient and got the correct medication for that patient" and "Whenever I have requested or asked if a particular resident has been seen by external health professional this has usually already been picked up and acted upon. I have never had any concerns in relation to customers not being seen by health professional or physiotherapists if this is necessary for the wellbeing of the customer."

The purpose built building is divided in to six living areas with communal facilities including a café, cinema and hair salon. The garden area was safe, well maintained and fully accessible for people to enjoy. There were raised flower beds and the garden was maintained by two volunteers and people living in the home with an interest in gardening. Pictorial signs were in place which made it easier for people to locate bathrooms and shared toilets. We saw that people's bedrooms were clearly labelled with their name. The area operations manager told us the home had been working towards making the ground floor more dementia friendly and the home overall more personalised. Ideas that were being considered included having street names for the six living areas so that people could have their post delivered to the street their bedroom was on instead of just the home. Another idea was to paint people's bedroom doors the same colour as their previous house front door to encourage ownership and recognition for people.

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. Staff were able to tell us about people's likes, dislikes and preferences. For example one person used to work with animals and loved farm activities. Another person loved playing the piano. Staff told us it was important to find out about people and aid conversations and building important relationships with people. A staff member said "This should be a nice part of their lives. We should adapt to the individual and make it person centred for them." Staff knew people's individual communication skills, abilities and preferences. For example staff told us of a person who was not able to verbally communicate their needs or wishes. Staff would ask the person a question and say to blink or squeeze their hand for yes or no.

People said they were cared for by friendly staff who kind, helpful and supportive. Comments included "The staff are fantastic here, they really care. And if my friend gets upset, they come and cuddle her. This home has got heart", "No complaints. Staff come round, crack a joke, and can't beat it when you have people like that", "I would recommend It to anyone if they were to come to a care home. One of the staff members was a brides maid at a wedding and she brought her dress in here and she put it on and showed us and that was very nice of her", "Staff are marvellous, really great will do anything for me. When you are down they come and give me support and a cuddle", "Looking after me well. They care about you, wonderful people" and, "They know me, I am very fond of them, really like a second friend. Sometimes I say I can't do it, I am helped then."

Staff appeared unrushed and there was a sense of calm across the home. We observed staff going to the assistance of other care staff if additional help was needed to support a person. Staff had time to sit with people, chat or reassure them if concerned. One staff was observed explaining the plot of a film to a person and other staff were seen sitting with people whilst they completed paperwork so they were on hand. One health professional said "I am very impressed with the care offered; they take great care to get a good history from patient or relatives about their earlier life and how that may impact on their current behaviour. They are always respectful and thoughtful about the resident's needs and care. I would be more than happy for any of my family to be cared for there." We observed one person in the lounge tell a staff member they were hungry. The staff brought the person a selection of cakes to choose from and left the rest by her in case they wanted more. Another staff offered to make the person a sandwich and knew how the person liked it prepared and served.

Staff spoke positively about their role in the home saying "Knowing I go home at the end of the day and I have achieved something and helped someone is the best thing about working here", "As senior staff I lead from the front and should be able to go in and care for anyone, roll my sleeves up and help. The welfare of residents is our priority"; "The best bit about working here is hearing about people's histories and meeting with the residents. It doesn't feel like work, but like I am a member of a big family" and "I treat people like they are my own family. I want to be proud and make sure they look the best they can."

Relatives were confident that people were well cared for by competent staff who knew people well. Relative's comments included "Staff are brilliant. One hundred per cent excellent, I can't fault them", "It has

restored my faith in youngsters, they are all so good, I am humbled by their brilliant care", "Care really good here. Lovely to know that she is looked after during the night time. They look in on her and keep an eye out because she wanders about" and "Staff are so kind to her. A really good friend to [X]." One health professional told us "All the staff are very friendly very professional in all manner of problems that arise and always happy to help and put people at ease with any situation." Another health professional said "The customer's at Ashwood are always well cared for. I spend a great deal of time at the home and can clearly state that staff are very caring and knowledgeable about their residents and their individual needs."

Staff we spoke with told us they treated people with respect. For example they would ensure they knocked on people's doors before entering and asked if it was okay to come in. During personal care they would ensure the curtains were closed and the person was covered. They said they would always ask for permission before providing any support. One staff said "My job is to be here for the residents. If a person declines support, I'll go back later. I don't give up." One health professional said "Residents are treated as I would like to be treated with dignity and respect. Staff knock on a resident's door before entering. Doors are kept closed whilst personal care is provided. I have never seen a bedroom or bathroom door ajar when care is being provided." We saw that people's care plans stated what elements of personal care they could manage for themselves and if they had expressed a preference for a female or male carer this was recorded.

Staff told us that people were encouraged to be as independent as possible commenting "When helping people I offer them to do bits for themselves. One person always makes their own drinks and others do as well" and "We encourage people to do as much as possible for themselves, we will write down mealtimes for them to help." On our arrival to the home we saw some people were up having breakfast in the dining rooms, other people had chosen to have breakfast in bed and others were still sleeping. There were no restrictions placed on people and they were able to move freely around the building and access the outside spaces. People who had a diagnosis of dementia lived on the ground floor and had immediate access to the garden so they did not need support in navigating around the building. One health professional told us "Where possible a resident's independence is maximised to promote their independence. Staff encourage and prompt rather than hands on care, again to maximise a customer's independence." Another health professional said "They encourage mobility with supervision; there is an open caring culture. They involve relatives and family as much as possible and also discuss and explain things to the residents as much as possible."

We saw on arrival some people were up in the communal areas, others had chosen to have breakfast in bed and others were still sleeping. People told us they were supported to get up when they chose commenting "I am never rushed, I get up as and when I want and I go to bed when I like", "I am never rushed in the mornings or at night" and "Never rushed. It's all very nice." We saw one person's sleeping care plan stated "[X] likes to go to bed early and does not have a set time in the morning to wake." This showed that the home took into account people's choices around their preferred routines. One person told us "I make all my own decisions. They have their rules and regulations here but I make my own decisions."

Good

Is the service responsive?

Our findings

Care, treatment and support plans reflected people's needs and choices. A one page profile was in place which had been personalised with photo and what was important to the person and how best to support them. Stickers had been placed on care plans as a quick reference guide to staff so they knew if someone had a Do Not Attempt Resuscitation form (DNAR) or a Deprivation of Liberty Safeguards (DoLS) in place. One person had a communication care plan in place which detailed how staff could offer choices to the person effectively and how the person would demonstrate to staff if they were not happy or needed something.

People and their relatives said they had been involved in drawing up the care plans commenting "I was involved initially in the care planning. Staff sat beside mum and myself. They took details. Nothing has really changed. If we see a problem we keep in touch with the girls [staff]" and "I came in for respite before living here. I was assessed and then my care plan was done. It was reviewed after six months."

We found for monitoring charts, such as for creams and repositioning, these were not always filled out consistently, leaving gaps which were not always identified by staff on the day. Some repositioning charts were in place for people who did not need to be monitored. For example we saw for one person they frequently declined to be repositioned. Staff told us the person should no longer be on a repositioning chart as they were now mobile. The chart was only meant to be in place while the person was ill in bed. For another person their care plan stated they were on a repositioning chart, however we could not find evidence of this. Again staff told us the care plan had not been updated yet and there was no need for the person to be on a repositioning chart. On one person's mobility care plan there was confusion around how many people were needed to support the person. Different care plans recorded either one or two staff for personal care and it was hard to ascertain which was correct. We fed this back to the registered manager.

People's needs were reviewed regularly and as required. One person said "They come in and say about my care plan. If you don't feel well they will come and chat to see if I am alright." Relatives told us that they had attended review meetings to discuss care plans and the on-going care of family members commenting "We had a six monthly review in January. I am very involved, they feed back to me automatically" and "They will let us know if anything changes in the plan. I have been to review meetings and know what is going on." We did find that when people's care plans had been updated, some information could be confusing to staff. For example in a person's breathing care plan it stated they became very breathless, which was made worse when they got anxious. The care plan stated they had two inhalers but on the review notes it documented one had been discontinued but this had not been updated in the main care plan.

Two activity co-ordinators, supported by staff, volunteers and some residents, planned and offered activities including group and one to one sessions. People had the choice of participating in a range of activities such as, quizzes, reminiscence, craft sessions, photography club, memory games, skittles, cinema and pottery. Outside entertainers including a theatre group, a pianist, a variety of musicians and an Elvis tribute act, supported the programme. One person had always been interested in photography and the activity co-ordinator told us "[X] used to be very interested in photography so we introduced them to digital cameras. Can't get over the difference in [X], will talk to people now and has had an impact other people as a result.

They have come out of their shell, [X] gives them confidence." We spent time with this person and they told us how they were trying out all kinds of digital cameras and had learnt to edits photos and adjust images. This person's photos of the garden and activities were displayed around Ashwood.

People told us "I have just done a skittles activity, we always have fun", "Some of the staff take you out to the shops if needs be", "Lots of nice things to do here-, I love it", "I love playing skittles. And word search and we have a big scrabble board in the dining room. We make Christmas cards and at Easter we made decorations", "I don't commit to anything but I do some things. I do a lot of reading and people do a lot of things that I can watch. I like to walk around the gardens with my daughter, we often have tea and cake in the gardens", "I do like it here; I have made a friend who has been a resident since I've been here" and "I go out into the garden and the staff take me out. Last year they took me to the hippodrome Bristol." One relative said "When [X] first came in they were not interested in anything, now joins in." One health professional said "Ashwood is a home where there is generally a lot of things happening to occupy the residents on a daily basis. This is not so in many other homes. Residents at Ashwood are generally happy and settled in their surroundings and families generally are pleased with the care provided to their relatives."

The garden was accessible for all and people spoke highly of the outside space commenting "I go and sit in the garden anytime. [X] plus the others go down regularly. You always find friends in the coffee shop or the garden", "They let you walk out in the garden when you like. They don't let anything happen to you" and "I am lucky, I can get all over the place, I sit out, there are seats outside." One relative said '[X] loves the garden, they come alive." We saw one person who loved the garden asked staff to be wheeled outside. A member of staff responded immediately and they spent time going around the garden area. Peoples' spiritual needs were respected and services were held weekly with ministers from the United Reform church, Church of England parish vicar, a Baptist minister and the in-house church group contributing. People living in the home led the singing and gave bible readings. A number of people also continued to go to their local churches. One person said "I am picked up and taken to church every week by one of the members."

Cleaning bits were available for people in the corridors if they wished to clean their own room. One person told us "I tidy my room and polish it myself. It's nice to have something to do. I want to do it, it's awful if you have just to stand and watch. They do a lot for me and I like to do a little back." We saw throughout our inspection people and their families enjoying spending time in the café. People talked about how much they appreciated this facility and how it tended to be the hub of the home. One relative said "[X] has been here a while. Very quiet and gained confidence. They get [X] to come and have a cup of tea gaining confidence in a relaxed session. Has made a real difference. More sociable and chats to others." Links had been established with the local community via the activity programme. A local community choir visited regularly and people benefited from the singing and involvement. Local school pupils visited the home to entertain and chat with people. One school was involved in designing a mural for one dining room. A design competition was being held and the winning design will then be painted on the wall.

People felt confident to raise any concerns they had and felt they would be responded to in a timely manner. Comments included "I've never had any reason to complain but if I did it would be to the person who runs it", "I previously complained about the food and the shortage of staff and I complained to the manager. We have a residents meeting and I am on the committee" "I know we could talk to anybody, I have no worries", "Not made any complaints at all, I am perfectly happy" and "Any worries go to the girls [Staff]. If we are worried we know who to see or go to the top." Copies of the complaints procedure was clearly displayed and contained information on how to complain and where to go if you felt the complaint was not resolved.

Requires Improvement

Is the service well-led?

Our findings

We observed at this inspection that the home was not displaying the ratings from the last inspection. A report was available in the reception area but this was not in clear view and was behind some other brochures. We raised this with the registered manager who informed us that it should have been up and was unsure why this had been moved. The registered manager took swift action to ensure this was reinstated during the inspection. The area operations manager told us "We like to act immediately on areas raised."

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home, however some of the issues we had identified during our inspection had not been picked up, including risk assessments and management around behaviour management and mental capacity assessments.

The registered manager told us they had recently started to use a new tool when reviewing concerns around people's weights. The new tool produced the results in a graph format and would look at the results monthly instead of across three months allowing faster action to be taken in response to identified concerns. We saw that the service was carrying out monthly audits of the medicine processes and that these were identifying and correcting shortfalls. Records showed that the shortfalls identified at audits were cascaded to staff through individual conversations and team meetings.

Falls were audited and analysed and anyone having fallen twice or more in the same month was flagged up as high risk and action taken including referral to the GP, testing for other infections or a medicine review. The registered manager said "We generically share learning with the team through care plan, however the falls lead could feed back to teams at care meetings. The care leads are doing workshops around what is a fortified diet, what is expected at mealtimes and infection control." The area operations manager informed us that the "Trust are looking at a different reporting system, and reviewing the incident system so the area operations manager will be alerted to review these also."

The registered manager from the last inspection remained in post at the service and had taken actions in improving the service since this time. People spoke positively about the leadership of the home commenting "I do speak to her, she is a cracker, she is intelligent, very clever, I have the upmost respect for her", "I can go and see the manager in her office, I just wish she would come around more often", "I think she is doing a good job, I have nothing to complain about" and "I speak to the person who's in charge, but the standards here are very high. I would recommend it to anybody, it is great here."

Relative's also praised the registered manager saying "I think she is doing a good job", "I think what they do every day is above and beyond, they're brilliant", "I know the manager, I think she is doing a terrific job", "The manager is approachable, and has always got time" and "I know the manager, it's a pretty well run place." One health professional told us "I I think it is an excellent care home and am impressed with the service offered. They respect the fact that it is the resident's home and give individualised care. I enjoy working with the staff who I have always found helpful, keen and supportive. They are willing to look at issues and learn from significant events." Another health care professional commented "I have always found

the management and staff alike always helpful and most efficient at dealing with any queries I may have".

Staff told us they felt well supported commenting "The manager is on the floor, if I need to I could go to her and the deputy", "The manager is very approachable, she has an open door policy. She's diplomatic but honest, very good at reading her team and very supportive, she's a good manager", "The manager is on the floor a lot and she's approachable" and "[X] [manager] is nice. She has an open door policy. Accessible to all staff, and is very open. She cares about the residents." The registered manager had a drop in slot every Friday so staff could come to her with any concerns. We saw that staff were able to attend team meetings and the registered manager told us the team leaders organised these and if staff wanted her to attend she would commenting "It's nice for them to have this control and be free to talk without me there." One staff said "If we come up with an idea she will do her hardest to make sure we get it." Another staff commented "The manager responds to requests for training. There is good training and good support."

People and their relatives were encouraged to be involved in the home and share their feedback and experiences. The registered manager held a coffee morning once a week for people to drop in and have a chat. Meetings were held so people could be kept informed about events affecting the home and the registered manager told us she had arranged a cheese and wine event for relatives to come in and join their loved ones and chat with her if they wished. An in-house magazine, 'The Ashwood News' provided people with a good source of information, listing forthcoming events, articles and photos taken by a person living in the home. The registered manager told us they were starting to do a newsletter for the staff team also as it was a big team to communicate with. We saw that the wrong deputy manager had been recorded in people's service user guides and some of these did not always have the person's name or key staff member recorded on for them to know.

People and their relatives spoke of the positive atmosphere at Ashwood and said the communication was good. Comments included "The welcome received from the receptionist sets the tone for our visit", "There is a good atmosphere, friendly and supportive", "Any problems I am phoned straight away", "There is good communication and information on the boards will tell you things", "Every time I come in, I am greeted with a smile, the receptionist is very friendly" and "It's a good atmosphere, smashing place all so nice."

The registered manager had a development plan in place which included increasing the use of volunteers in the home, one to one engagement with people and holding Dementia friends sessions. The registered manager said "We have moved on a lot since the last inspection. Care teams are more settled; we have got a handle on training and got a Dementia lead in place. I just feel we are in a better place as a home to move forward. The activity post has been recruited for, we have recruited into care leads posts now the nurses have gone and the dynamics are more settled."

The registered manager had been attending training in Dementia, end of life and participated in an oral hygiene project which involved dentists coming into the home to see what training they would benefit from. The registered manager had been left with a training package on how to correctly clean people's teeth and dentures and planned to hold workshops with staff to cascade this knowledge. The registered manager commented "I have no worries over support, it's brilliant, [X] [Area operations manager] brings another dimension and visits once or twice a month if not more."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make specific decisions there was no evidence on the mental capacity assessments of who was consulted, what the discussions had been and how the decision was made in the person's best interest. We found that where conditions on DoLS authorisations were in place, the conditions were not always consistently met and recorded Some care plans stated a person had LPA for health and welfare, however when we checked the providers records, the person only had a LPA for finances. This meant staff were not consistently aware of who to consult when making specific decisions about people's care and treatment. Regulation 11 (1).