Mrs L Watts Ms J L Watts

Ashurst Place

Inspection report

Lampington Row
Langton Green
Tunbridge Wells
Kent
TN3 0JG

Tel: 01892863298
Website: www.ashurstplace.com

Date of inspection visit:
13 May 2016
20 May 2016
27 May 2016

Date of publication:
24 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 13, 20 and 27 May 2016 and the first two inspection days were unannounced. The inspection team consisted of one inspector on the first and third days and two inspectors on the second day.

Ashurst Place is a large period home set in 23 acres in the village of Langton Green near Tunbridge Wells. The service provides personal care and accommodation for a maximum of 37 older people. At the time of our inspection there were 29 people living at the home some of whom required support to manage health conditions such as diabetes and some of whom were living with dementia, the effects of stroke and learning disabilities. Some people required assistance with moving around the home.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

People told us they felt safe and staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. However we identified risks that the registered manager and registered provider had failed to identify or act upon including areas of poor maintenance which placed people at risk of harm.

The registered provider followed safe recruitment procedures to ensure staff working with people were suitable for their roles. However, staffing levels were not based on people's needs and did not promote their safety and wellbeing.

Medicines were not always stored safely and necessary checks had not been made to ensure medicines were safe to use.

The registered provider had not ensured that the requirements of the Mental Capacity Act 2005 were followed and people were therefore at risk of having their liberty restricted unlawfully.

People received medical assistance from healthcare professionals including district nurses, GPs, chiropodists and the local hospice. However, staff did not have the guidance they needed to ensure people's health needs were met.

People and their relatives told us staff were kind and caring however the registered provider had not ensured that people's privacy was respected.

People could not be assured they would receive responsive care as assessment and care plans did not provide staff with up to date detailed information and guidance. People's preferences and social needs were not always respected even when known and people told us that their days were often without

meaningful occupation.

The registered provider had not ensured that monitoring checks and audits undertaken were effective, identified concerns and led to improvement. Where people and their relatives had given feedback this had not always been acted upon.

People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences and restrictions.

People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed and their involvement encouraged.

We have taken enforcement action and issued two warning notices. Details of the warning notices can be found at the end of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.
Staff understood their safeguarding responsibilities.

People were at risk of harm because not all risks had been effectively managed and there were areas of poor maintenance

There were not sufficient staffing levels to safeguard the health, safety and wellbeing of people.

The registered provider had not ensured that medicines were stored safely

Is the service effective?

Requires Improvement

The service was not effective.

The registered provider had not ensured that staff had the necessary skills and knowledge to meet people's needs.

The registered provider had not ensured that the requirements of the Mental Capacity Act 2005 were followed and people were therefore at risk of having their liberty restricted unlawfully.

People were provided with adequate nutrition.

People were not consistently supported with their health needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they found the staff kind and compassionate.

People's privacy was not always promoted or respected.

Staff respected people's right to independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be sure that their needs would be met as assessment and care plans were not always accurate, detailed or up to date.

Some people did not have their social needs met and were not supported to take part in meaningful personalised activities.

People knew how to make a complaint and were given opportunities to give their views.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not ensured that there were systems and leadership in place to effectively monitor the quality and safety of the services provided.

People and staff liked the registered manager and the home's informality and open culture.

Ashurst Place

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 comprehensive inspection was carried out in response to concerns that were shared with us and 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 was carried out on 13, 20 and 27 May 2016 and the first two inspection days were unannounced. The inspection team consisted of one inspector on the first and third days and two inspectors on the second day.

We gathered and reviewed information about the service before the inspection, including notifications we had received from the provider. This is information the provider is required by law to tell us about.

We looked at 10 sets of records which included those related to people's care and medicines. We looked at people's assessment of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and two staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service and, we sampled the services' policies and procedures.
We spoke with eight people who lived in the service and four of their relatives to gather their feedback. We spoke with one health care professional, one commissioner, the registered manager, the provider, the administrator, eight of the care staff, the cook, and two members of the housekeeping team.

The service had previously been inspected on February 2015 and met the requirements of the health and Social Care Act 2008 and was rated as "Good".

Inadequate

Is the service safe?

Our findings

People told us they felt safe and well cared for. One person told us, "I feel safe here, they're lovely people" and another said "There's nothing wrong with this place." One person's relative told us they had confidence in the staff, "They are really cheerful, helpful, kind and I am not at all concerned about safety. They constantly worry about safety"

Although people told us they felt safe, we found that the systems to protect people from harm were inconsistent. For example the home had environmental risk assessments for particular areas within the building. However our inspection identified risks that the provider had failed to identify or manage. There were areas of the home that required maintenance and that presented a risk to people. One person's relative told us, "I think things could be improved a bit…I think the equipment is working but a few things could be updated, certain bathrooms etc." In one upstairs bathroom the toilet was raised on a small step. The flooring around the toilet was in poor repair and had lifted which meant it was not sealed properly and made effective cleaning difficult. This increased the risk of the spread of infection. The ceramic part of the toilet was not clean. The provider subsequently repaired the flooring. The bathroom had a large sash window and one sash had broken which posed a potential risk of harm to people and staff. The bath had a bath chair and on the side of the bath there was a label that recorded it had failed an inspection in January 2016 and was "Not in Use". We asked two staff about the bath and both told us it was regularly used. The provider told us the bath chair is now out of use. We showed the registered manager this bathroom and on the third day they had taken action to rectify and reduce the concerns.

Two people had their rooms positioned down a corridor that led to the kitchen. This corridor was poorly maintained with a change in level on the floor and a bathroom that was carpeted. Having carpet in an area where soiling was likely to occur or where it was likely to get wet meant there was an increased risk of infection and meant this area could not be kept clean effectively. The provider has told us that this bathroom is not used for personal care of people living at the home. The carpet was subsequently removed by the provider.

The registered provider employs two maintenance workers. We were showed the maintenance log where issues were recorded for action. One entry from the 06 May was marked "Urgent" and stated that there was a broken sash in one person's room. When the inspector and registered manager went to the room, the window sash was still broken. The provider has told us that this problem has now been rectified, subsequent to the inspection. We arrived to inspect the home at 7.10am and on arrival found that one person's bedroom door was sounding an alarm as the door closer battery required replacement. In the maintenance log, another person's bedroom required a light bulb and when we visited their room this had not been replaced, though they had other sources of light in their room. The registered manager acknowledged the concerns and told us, "It's good to have another set of eyes; you sometimes get complacent and don't see things." Some of these maintenance issues were rectified immediately and others were done by our third inspection day.

We asked the registered manager to show us records of key areas such as fire checks as well as gas and

electrical servicing that would ensure the premises and equipment were safe to use. However records supplied by the registered manager showed that the emergency lighting and fire call points that were due to be tested weekly had not been tested since 07 February 2016. We looked at a number of portable appliances in communal areas and people's bedrooms and there was no evidence on the day of our site visit that these had been checked to ensure their safety. The provider subsequently produced evidence that PAT tests had been carried out. A gas safety inspection report dated April 2016 stated, "Boiler in very poor condition….. we advise to replace boiler as soon as possible." The report called for a carbon monoxide detector to be installed at the top of the stairs. Despite the report highlighting serious concerns no action had been undertaken to address the risks identified.

On the third day of our inspection the manager had taken action to rectify some of the maintenance issues including the installation of a carbon monoxide detector and the replacement of broken window sashes. Following our inspection documents were supplied that indicated weekly tests for the emergency lighting and fire call points had been done. The registered manager had also arranged for a gas safety expert to attend and together they had agreed that the boiler would be replaced next year. They had also considered a contingency plan should the boiler break down before it is replaced

We looked at food storage and found food such as tuna mayonnaise and meat paste that had not been labelled with the date of opening. The cook acknowledged this was not safe practice and threw away multiple jars and other foods immediately. However there had been a large amount of food that was open and not labelled, which meant staff making up snacks had no way of knowing whether they were safe to use. The registered provider has told us that they will use labelling of food in line with good practice guidance.

The evidence above shows that the registered provider had not taken appropriate timely action to identify and reduce risks to people's safety and welfare and to ensure the premises was effectively maintained. This was a breach of Regulation 12(1)(2)(b)(d)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager and provider to describe how they determined staffing levels but they were unable to show us anything that evidenced staffing levels were based on an analysis of people's support needs. One person's care records included an assessment by health professionals dated December 2015. It stated, "On night shifts (X) threatens staff…staff advised personal care can be delayed due to (X)'s behaviour which is worse at night". The assessment concluded that the person required two to three staff for personal care. Records showed that the registered manager had not consistently provided assessed levels of staffing.

Staff told us "There's not enough at night" and "We definitely don't have enough staff at night." Rotas showed that staffing levels remained consistent with two staff provided from 8pm to 8am to support and care for 29 people, some of whom were living with dementia, anxiety and sensory loss. Three relatives told us they had concerns regarding staffing levels. One explained, "From about 2pm and into the evening you just don't seem to see the carers around at all….sometimes people are having to wait a long time for the toilet or to go to bed as there's just not enough staff."

Some people were at risk of pressure sores and others required assistance with all aspects of personal care. This meant that at times whilst staff attended to people's personal care needs there were insufficient numbers of staff deployed to provide adequate supervision to other people. We looked at people's care records and found that one person had required repositioning whilst in bed but had not always received the care they needed, which meant they had been put at risk of developing pressure sores. Accident and Incident records showed that since October 2015 there had been 42 incidents where people had fallen at

night.

The home had recently advertised for staff but was yet to recruit. As a result two staff each worked 60 hours a week covering five nights between them. On some nights the lack of staff meant there was no senior on duty to take responsibility for the home. The minutes of the most recent night time staff meeting stated, "We have always needed extra staff due to holiday and sickness cover and also day staff are not willing to cover nights anymore". One person's relative told us, "The main thing is staffing issues, they're always short staffed" and another person's relative described times when they visited and "Can't find a living soul". Rotas showed that on some days numbers of staff fell below what the registered manager said was required. For example there were days when staff were absent due to sickness and their hours were not covered. The rota showed that on one day staff were undertaking training and there were insufficient staff deployed.

We looked at bathing records and found that many people required the assistance of staff to have a bath or shower. However records showed that some people had not had a regular bath or shower. We spoke with five people, four of which told us they would like a bath or shower more often. One said "I would love a shower!" Another said, "You can have a shower but not every day." Another person told us, "I don't have one very often, they (staff) say they haven't the time or the water." Records showed that one person who required the assistance of two staff had last bathed on the 17th March. Although on the 20th March they had been offered a bath and refused, there was no indication that they had regularly been offered a bath since. Another person told us, "I don't get baths often…I only have a bath every month to six weeks." We looked at the person's bathing chart which showed that they had not been supported to have a bath since April 2016. The person told us they missed having a bath as they used to have one daily before they moved to Ashurst Place. They explained that although they had requested a bath staff had declined; "I don't think they (staff) have the time to bath you. When I've asked they've said no sorry, we've got so and so to get up or so and so wants one."

The registered provider had not ensured there were sufficient numbers of suitably skilled and competent staff deployed to meet people's needs and ensure their wellbeing and safety. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a Medicine Administration Record sheet (MAR) with a photograph of the person to ensure staff gave the correct medicine to the right person. However we found that storage of medicines was not safe. For example the medicine room was located off the main entrance area with a simple slide bolt to "lock" it and we were able to enter the room easily. We found a box of prescribed topical medicines unlocked in the room which meant that those people who were able to walk freely and independently around the home were potentially able to access these. Some of the medicine labels had been rubbed off and when we asked a night staff member who they belonged to, they told us they did not know. We found many topical medicines and medicines in solution that had not had the date on which they were opened recorded. This is important as it ensures they remain safe for use. The temperature of the medicine room was taken twice a day and during our inspection reached over 25 degrees. Records showed that even during winter months the room was hot and on four days in February it had been 26 degrees. However some people had been prescribed medicines that stated they were not to be stored in a room over 25 degrees. Despite staff recording that the temperature was more than it should be, no action had been taken to ensure medicines remained safe to use and were unaffected by heat.

We discussed this with the registered manager and on our second day of inspection action had been taken to address the inappropriate storage of medicines, having placed a lock on the medicine room and put in place an air conditioning unit to regulate the temperature.

However the registered provider had not ensured that there was safe storage and administration of medicines. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home had guidance for reporting abuse and there was a copy of the local authority's multi-agency safeguarding vulnerable adult's policy, protocols and guidance. This policy is in place for all care providers within the Kent and Medway area and provides guidance to staff and to managers about their responsibilities for reporting abuse. All the staff members we spoke with had undertaken training in safeguarding people from abuse within the last year. All were clear and confident in their role in safeguarding people should they suspect abuse. Staff were clear about their whistleblowing responsibilities. One staff member told us, "If I saw anybody acting or doing anything untoward to any of the residents I would definitely blow the whistle. That is something I would not tolerate." Another staff member said, "We have a whistleblowing policy and I would go straight to (X) (the registered manager) or CQC and safeguarding."

One person told us they had felt unsafe when another resident kept walking in to their room. Staff had supported the person to change rooms so that this no longer happened and they now felt safe. Other people had lockable cupboards to keep key items in and to ensure their possessions were kept safe.

Requires Improvement

Is the service effective?

Our findings

People told us they liked staff. One person said, "The girls are good, very good" and "They're kind, very helpful." Staff received a range of training and one staff member explained, "Training is mostly DVDs. You watch the DVD and then you have questions to answer. By the end of our inspection we saw that all staff had received practical training in undertaking moving and handling.

Care plans did not consistently contain the information and guidance required to ensure people's needs were effectively met. We observed two members of staff assist a person to transfer them from their wheelchair to a standing hoist. When this was unsuccessful one staff member left the person to get another hoist. When they returned they placed a sling around the person and were joined by a third member of staff who stayed with them to assist and advise them on transferring the person. The person's resident risk assessment stated they required a hoist and their support plan summary stated they required "The assistance of two carers to get in and out the chair." We asked one senior member of care staff what sling the person used and they told us they did not know. We looked at the person's hoist and sling assessment and it was incomplete and inaccurate. It gave no guidance as to the size and type of sling they required. It stated that the person required a particular type of hoist that the home did not have and therefore could not use. The provider explained that the assessment tool had not been effectively used or amended for the home and people in it. This meant that staff did not have the correct information they needed to deliver effective care. The provider told us they were awaiting advice from an occupational therapist and on the third day we found that guidance regarding people's moving and handling needs had been updated.

Care records showed that people were supported to access a range of health professionals including speech and language therapists, GPs, district nurses, opticians and chiropodists. However care plans, risk assessments, charts and daily records did not always contain detailed information about people's care needs and we found staff had not always delivered the care that people had been assessed as requiring. For example, during our inspection one person remained in bed and records showed they spent the majority of their time in bed. This person had been prescribed barrier creams as they were at risk of pressure sores. However when we visited their room, the topical medicines were not dated and simply stated "as directed". There were no records that stated how often the person was to have these applied or records to show when they had been applied. There was no body map to guide staff as to where they should apply the medicine. The person's care plan summary stated "Lower legs red and dry, cream to be applied regularly. Also noticed small breaks in the skin on both shins". The person had also been prescribed a topical medicine that was to be applied four times a day. There were no records to show this had taken place. The registered provider has told us they have improved topical medicines charts since the inspection.

One person had a pressure area identified in April 2015 but their resident risk assessment simply stated the person "has a pressure area…." The assessment gave no guidance to staff as to the actions they should take to manage this. Although the person had a new airflow mattress in March 2016 they had previously been reliant on staff relieving pressure by regular repositioning. However there were no records to guide staff as to how often the person was to be repositioned. We asked staff how often they thought repositioning should occur and they did not know, one staff member told us, "Well I would turn them regularly every 2-3 hours, I

can't say about other staff". Records gave no indication that staff had repositioned the person according to clear guidelines as there was no consistent approach to repositioning the person. On one day the person's repositioning chart showed they were repositioned at 5 am and then not again until over 18 hours later at 11.12 pm. On other days the same week, the person was not repositioned for nine and half hours and on another day they remained in the same position for 19 hours. This meant that the person had been placed at risk of pressure sores.

We spoke to the registered manager about this and on the third day of our inspection the person's care records had been updated to include repositioning every four to six hours.

However the above evidence shows that the provider had not ensured that people received safe care and treatment that effectively met their health needs. This was a breach of regulation 12(1)(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider explained that they undertook a yearly appraisal of staff and supervision meetings were held every two months. The Care Quality Commission had previously received information regarding the conduct of one staff member and the provider had told us they were taking action to address this.

Staff received training in the principles of Mental Capacity Act (MCA) 2005 and were able to describe them. We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the registered manager and provider. The MCA states that when people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted. It provides a process by which a person can be deprived of their liberty when they do not have capacity to make certain decisions and there is no other way to look after the person safely.

Care records stated that some people were living with dementia and staff told us some people lacked capacity to make certain particular decisions. We found that care plans did not give clear guidance regarding people's capacity to consent to care and treatment. One person's care plan stated "…X cannot address what she wants and cannot understand what people are trying to communicate to her." The person's care plan summary stated; "Must know where (X) is at all times ." This showed that the person was the subject of continuous supervision and their freedom restricted. Therefore an application to the local authority to deprive them of their liberty should have been submitted.

We found that assessments of people's capacity to make decisions had not always been undertaken. For example, one person was subject to a restriction through use of bed rails. Staff told us this person lacked capacity but their bed safety rail assessment stated that the assessment had been discussed with and agreed by the person.

The registered provider had not ensured that the requirements of the Mental Capacity Act 2005 were followed and people were therefore at risk of having their liberty restricted unlawfully. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they enjoyed their meals. One person explained, "The food is very good. You can't grumble about the food" and another said "We have what we like for breakfast it's very good." We spoke with the cook who was aware of people's dietary requirements and kept lists that included the names of people requiring a soft diet, those people who had diabetes and those people who did not eat meat. People's likes

and dislikes were listed and respected. We observed lunchtime and it was relaxed with people receiving the support they required. For example some people used plate guards, others straws for their drink and others had particular cutlery. We were shown previous menus and could see that people were given choice and a varied diet. Homemade cakes and treats were provided and on the first day of our inspection the cook had prepared a birthday cake for one person.

People told us they valued the gardens and setting of Ashurst Place; "It's a lovely place you get to look at the countryside." They described how they enjoyed the animals and wildlife that came into the grounds. One person's relative told us they had looked at other homes and "We quite liked the environment, the grounds are beautiful. It could be really nice as it is a lovely building."

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind. One person told us how they got on with two particular staff; "They listen to you and have a joke with you." Other people told us, "I like living here – I must say all the carers are very nice." One staff member described what they liked about working at Ashurst Place, they told us, "The best thing about this place is the residents. I love the residents"

Although people told us staff were kind we found that the provider had not ensured that people's right to privacy was always respected. For example, on the first day of our inspection we observed that the bedroom door of one person who was in hospital was left open for anyone to enter. We asked people whether they were able to lock their doors and they told us they were unable to. One person explained, "I've never had a key" and another said, "I haven't got a lock which I think is very wrong as people can walk in….I think we all should be able to lock our doors." During our inspection we were speaking with one person in their room when the registered manager came in without having been invited to do so.

One person's relative told us that some people's bedrooms were used by visiting health care professionals and a hairdresser. They explained that one person was regularly asked to leave their room that was positioned on the ground floor, so that other people could be seen by a GP in the person's bedroom. On the second day of our inspection we observed that this person's bedroom was used by a visiting chiropodist to undertake foot care for a number of people requiring treatment. This meant that the person was unable to use their room. We asked the registered manager about this and they told us that they had asked and gained the person's permission to use the room. However Ashurst Place is a large home that had other rooms that were vacant and this arrangement did not respect the privacy of the person who was accommodated in this bedroom.

The registered provider had not ensured that people's privacy was respected. This was a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Although we found that people's privacy was not always respected we also observed that staff demonstrated compassion and care and there was warmth between people and staff. The home's website stated, "It's the real connections and relationships that we have with our residents that makes Ashurst Place Rest Home different." One person's relative told us, "I've never known her so content…she receives nothing but kindness….as far as I am concerned they could show other care homes how it is done."

Staff knew people well and were able to describe their needs. One staff member told us how one person became anxious and how they offered comfort and support. They explained, "I offer him support, I try and keep at a level, softly speaking and I tell him he is in control." Earlier in the day we had observed the staff member do exactly this, treating the person with respect and compassion, they knelt down to the person and offered reassurance and spoke in a way that provided comfort.

We observed humour and banter between people and staff. People told us staff were kind, "Sometimes they

give peoples' back a rub." And another told us, "They're all wonderful." One person showed us their room and showed us plants they had been given by staff and a picture that one staff member had brought in for the person because they knew they liked elephants.

One health professional described how people's individuality was respected; "They do tend to treat everyone as an individual." Some people who were able to walk independently were able to enjoy independence, coming and going from the home as they saw fit. People's independence was respected and one person told us how they were able to use taxis to access local facilities and attend appointments. One person carried a small contact card with essential information should there be an emergency whilst they were out. Another person had a high visibility jacket for if they were walking at night.

People were offered choices such as a choice of drinks, a choice of meal, where to sit at lunchtime and one person chose to have wine with their lunch and this was respected. The registered manager told us, "It's a boutique home. Every room is individual as every person is individual." We observed that people's rooms were highly personalised and included art, photos and possessions important to them. One person had a summerhouse in the garden dedicated to local history.

Requires Improvement

Is the service responsive?

Our findings

People had mixed views as to whether the care they received was responsive and person centred. They told us that although staff were kind they were busy and that there was not enough to do. We asked one person what they liked about living at Ashurst Place and they replied; "To be honest it's nothing special." One person's relative told us that improvement was required; "…I think if there were a few general improvements; layout, more carers and more activities…."

People could not be assured they would receive responsive care as assessment and care plans did not provide staff with up to date detailed information and guidance.

The registered manager carried out a basic assessment of people's needs before they moved to the home. We looked at examples of assessments and found these were not sufficient to ensure people received effective care. The assessment framework was a simple tick box format that considered a range of needs including mobility, behaviour and communication. One person's assessment had been undertaken by the registered manager in January 2016 and we found it to be incomplete and inaccurate. The assessment included a section that considered hearing needs. This stated the person had good hearing when the person required the use of hearing aids for both ears. The provider told us that the person had been admitted with significant injuries but their assessment did not detail these and the section titled "Known medical conditions and history" was left blank. The provider explained that the person was admitted to the home following a serious incident but their assessment gave no consideration that they may need emotional support following the incident. The section for behaviour was simply ticked as "Alert" and the assessment of their communication needs was ticked as "Mostly retains information and indicates needs verbally".

Although a care plan had been developed for the person this did not provide staff with detailed guidance that would ensure the person's needs could be met. For example the section titled "Social and emotional needs" simply recorded their physical and learning disabilities. There was no further detail to advise and guide staff as to how they could meet the social and emotional needs of the person. The person's care plan stated that the person "Due to her learning difficulties can find it hard to express herself fully" but gave no further information as to how staff were to respond to the persons needs and offer effective support at such a difficult time.

Another person had been discharged from hospital two days prior to our second day of inspection. Whilst in hospital they were diagnosed at risk of a life threatening condition and prescribed medicines. Their care plan and risk assessments had not been updated since March 2016 despite them having been hospitalised since then. Their care plan and risk assessment gave staff no guidance as to the how to manage the associated risks of being on such medicines including the need to avoid certain foods. We raised this concern with the head of care who told us they would take action.

The above evidence shows that accurate, complete and up to date information was not in place to ensure people received the care they needed. This was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home organised a wide range of themed days and parties throughout the year including St Patricks Day, an Easter party, Halloween and Christmas parties as well as events such as Mothering Sunday and BBQs. However people told us that on most days there was little to occupy them. One person's relative told us, "There are none. Everyone you speak to will say there is nothing going on". Another person's relative explained, "They don't do a lot to stimulate them." We asked people what they did to fill their days and one person told us, "Not a lot. Like we are now, sit and look at each other" and another told us, "We would like to go out occasionally but don't have chance…I have never seen the ones in wheelchairs go out." And, "If the carers aren't busy they do something like throw a ball".

We observed that most people were seated in the lounge area with the television on. One person told us, "There's not much you can do here…. too much TV on." One person's relative told us, "My mum hates the TV on from 10am to 10pm……it can be a very long boring day." We looked at the diary for the previous eight days which showed that ball games were recorded as the activity for three of the days and card games and quizzes for four of the days. During our inspection we observed that only a couple of people took part in the card game that was being played, which meant that the majority of people were without occupation either in their rooms or in the lounge area.

Another person told us, "No they don't have enough to do; some of them are in their rooms all the time." We were given a copy of the homes brochure which stated "Excursions, entertainment and organised shopping trips are regularly arranged" However people told us this was not the case. One person's relative told us, "They have had one outing since August 2014…that's the only one I know about." One person said, "It says all the things they do….and I have yet to see them." Another person told us "I can't understand why they haven't got any transport. Even in the brochure it says about going out and shopping and we don't do it."

We asked a staff member to show us records of when particular individuals had undertaken activities but they told us they were unable to. We looked at the care plan of one person who was living with dementia and was registered blind. Their social and emotional care plan gave no guidance as to how staff could effectively support them and instead simply recorded that the person "Feels quite fit in himself. No other issues." In their care plan there was a section that recorded their hobbies and this gave no guidance to staff as to how the person could be supported to undertake activities that were of interest to them. The person had completed a questionnaire regarding the home's activities and requested "more activities for blindness-gardening."

One person told us, "There is nothing to do here. We never go out". They described how they used to enjoy sport and loved badminton. They told us they had a badminton partner for 40 years. Their care plan recorded that they liked to "Sing, listen to music and dance…..she enjoys anything physical." On two days of our inspection we observed the person sat in the lounge with no activity offered other than card games.

People did not always receive personalised responsive care that met their needs. Some people were at risk of becoming socially isolated with little activity to stimulate or interest them. This was a breach of Regulation 9(1)(3)(b) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they were supported to maintain links with their family and friends. Family members were encouraged to visit and take part in events. Relatives we spoke with told us they felt welcome and described a warm atmosphere. We saw that one person had written on three separate occasions thanking staff for the support they had been given. They wrote, "You have made a very difficult time bearable with your care and kindness."

We asked people about their experiences of living at the home. As we sat in the main lounge we observed

that people spoke freely and openly in front of staff even about their frustrations which showed there was no fear and a culture of openness.

We looked at minutes from residents meetings held in February 2016 that showed the registered manager was present and people discussed activities, food and any issues they wanted to raise. Ashurst Place had had a complaints procedure in place and people told us they could make a complaint at any time and would feel confident speaking to the staff or the registered manager. The policy included timescales for making and responding to complaints and contact details for the Care Quality Commission. The provider explained that there was an open door approach that meant people could offer feedback informally and as result this meant that complaints were rare. We looked at records and found that the home had received four written compliments this year and had a record of one complaint since they were last inspected.

Inadequate

Is the service well-led?

Our findings

The registered manager and provider were approachable and liked by both people and staff. One staff member told us, "They are very supportive…" and another said, "They are good bosses. You can go to them with concerns". Another staff member told us how they respected the provider and manager and had become friends with them as a result of their family member having lived at Ashurst Place.

The registered manager and provider had not ensured that they effectively monitored and improved the quality and safety of the service. We found that there were quality and safety concerns that the management team and their systems had not identified. The registered manager explained that they shared the management responsibility with the provider and told us that they were less confident in the paperwork than the provider as "I am a hands on manager". However we identified practical safety issues that placed people at risk and that they had failed to identify or act upon, for example the maintenance of the building and its equipment. We looked at maintenance records that identified risks which were not acted upon. The registered manager acknowledged that their systems had failed to identify or act upon risks to people's safety. They told us, "We don't mind you coming in because we can rectify it….whatever the outcome is we learn."

Both the registered manager and the provider acknowledged that records were incomplete and inaccurate and explained that it was proving a complex task to update everything. The provider told us that they believed records had been changed or moved by a member of staff that they had delegated key responsibilities to. This staff member had now left. The registered provider had been working to update gaps in records. However, at the time of our inspection there were significant gaps in key records.

There were not effective management systems in place to monitor the quality of the service people received. We asked the registered manager whether they undertook an audit of personal care and they told us there was no such audit. The provider showed us a document that listed people's preferences but had not undertaken any checks to see that these were being respected. We looked at a complaint that had been received in July 2015. It alleged that people were "Not receiving showers or baths just a flannel wash in the morning…" The registered manager had investigated the complaint and concluded "I have looked into paperwork and found an error where we can't identify when residents had a bath, so this has been rectified and everyone is being asked each day if they would like a bath or shower." During our inspection we asked to see records that demonstrated people were offered and had received a bath or shower. However the records showed that some people had not consistently received either and this was confirmed when we spoke with people.

A member of staff was in charge of medicines, and the provider informed us that regular checks and audits of medication are undertaken. However, these were not effective in ensuring the safe storage, administration or disposal of medication. We showed them medicines where the label had been rubbed off, where the medicine had not been dated when opened and where the temperature of the room exceeded the safe limits specified on the medicine packaging. Their checks had not identified these.

Accident and incident records showed that there had been 7 occasions since 17 October 2015 when people had fallen in the lounge and conservatory areas of the home. We looked at feedback that had been received in February 2016 where one person's relative stated they would like, "A better call system in the conservatory and lounge, as out of reach- so people have to get up and call for assistance." We asked the registered manager and provider for examples of how they had taken action to promote people's safety when given feedback. The administrator gave us an example of how one person liked to sit in the lounge by the conservatory but their daughter had raised concern as this meant that they were not sat near a call bell. The administrator explained, "We moved him straight away to a chair that was near a call bell.

The provider and registered manager lived in a house in the grounds of Ashurst Place and told us they were available every day to monitor the service. There were photo boards with the managers' name and photo on display. However three relatives told us they were unclear as to the management arrangements at Ashurst Place which showed that there was not clear leadership. We asked one person's relative about their views on the management of Ashurst Place and they told us, "It's hard for me to say. Sometimes you want to speak to the manager and he's often away. I don't see him very often." Another person's relative explained that it had taken them "several months to work out who the manager is….I thought it was x….I can't remember the managers name". Another person's relative told us, "I have never spoken with (X) (the provider) - she has never introduced herself."
There were systems in place to monitor some aspects of the quality of the service people received however the feedback was not used to drive improvement. For example, questionnaires were sent out to relatives and health care professionals. However two people's relatives told us these did not always lead to improvement. One person's relative told us "If I mention issues in a gentle way they will not always do it…..But I don't want to rock the boat". Another person's relative told us, "I will say if I'm concerned but whether it changes the issues or not, I'm not sure. "

People living at Ashurst Place were asked for their feedback regarding their experiences and asked to comment on the care they received as well as food and activities. Residents meetings were also held. One person's relative told us there had been a residents meeting in February 2016 and relatives were invited. They explained that as the meeting was at 3pm on a Monday not all relatives could attend due to work commitments. They also said, "We didn't get any feedback from the meeting in February." At the February residents meeting people asked for more outings, an activity by a physiotherapist and a full time activities coordinator. The minutes of the meeting recorded that one person had said that they were willing to contribute financially. Whilst some of these requests had been acted upon others had not and records showed that the registered manager's response indicated that these requests could not be met due to finances.

Systems were not always being used effectively to assess, monitor, record and improve the quality of service to people. This was a breach of Regulation 17 (1)(2)(b)(c)(e)(f) of the health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The registered manager and provider had a clear vision for the home and told us "We want to look after the elderly as best as possible and look after our staff" They described how they wanted to create an atmosphere that was "Homely and not clinical." Staff were clear about the ethos and vision for the home and told us, "Residents feel involved, they're not just looked after, we're like a massive family." One person's relative told us how any visitors they had brought had always commented, "Wow what a setting- what a lovely environment." They told us, "I think it's a very friendly and warm approach- together they're (the registered manager and owner) a very good team." One health professional told us, "I have a lot of faith in Ashurst Place…" They told us that the registered manager and provider had created "A home from home."

The registered manager and provider were involved in a local provider forum which provided an opportunity to share ideas and good practice. They also looked at websites and talked to professionals such as GPs, and district nurses to keep abreast of new practice.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive personalised responsive care that met their needs. Some people were at risk of becoming socially isolated with little activity to stimulate or interest them. This was a breach of Regulation 9(1)(3)(b) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured that people's privacy was respected. This was a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured that the requirements of the Mental Capacity Act 2005 were followed and people were therefore at risk of having their liberty restricted unlawfully. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The registered provider had not taken appropriate timely action to identify and reduce risks to people's safety and welfare and to ensure the premises was effectively maintained. The registered provider had not ensured that there was safe storage of medicines and that people received safe care and treatment that effectively met their health needs.
This was a breach of Regulation 12(1)(2)(b)(d)(e)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA RA Regulations 2014 Good governance Accurate, complete and up to date information was not in place to ensure people received the care they needed. Systems and feedback were not always being used effectively to assess, monitor, record and improve the quality of service to people. This was a breach of Regulation 17 (1)(2)(b)(c)(d)(e)(f) of the health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were sufficient numbers of suitably skilled and competent staff deployed to meet people's needs and ensure their safety. Not all staff had received the appropriate support, training and guidance to ensure they could deliver care and treatment to service users safely and effectively. This was a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning Notice