Lifestyle Care Management Ltd

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

Summary of findings

Overall summary

We conducted an inspection of Ashmead Care Centre on 11, 13 and 14 January 2016. The first day of the inspection was unannounced; the provider knew we would be returning for a second and third day. This was our first inspection of the service since the provider's new registration with the Care Quality Commission (CQC).The service was previously registered with CQC under a different legal entity.

Ashmead Care Centre is a care home with nursing for older people with dementia and/or nursing needs. There were 95 people using the service when we visited.

There was a registered manager at 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 provider was not meeting the requirements of the Mental Capacity Act 2005. We saw examples of documentation being signed by next of kin without them having the legal authority to do so and some people's liberty was being unlawfully deprived. Most staff were unable to demonstrate an understanding of the issues surrounding consent. We also found that restrictions were in place for some people without the necessary authorisation.

Procedures were in place to protect people from abuse. However, staff understanding of how to recognise abuse varied and some staff were not aware of the provider's whistleblowing procedure.

Staff had completed medicines administration training within the last two years and were clear about their responsibilities. Medicines were administered, recorded and stored safely. However, we saw some creams did not include the date of opening or expiry date and some creams were in other people's rooms which increased the risk of cross contamination.

Staff demonstrated an understanding of people's life histories and current circumstances and most staff supported people to meet their individual needs in a caring way. However, we saw varying levels of interaction between care workers and people using the service.

People using the service and their relatives were involved in decisions about their care and how their needs were met. People had care plans in place that reflected their assessed needs. However, we saw that not all care records were updated as people's health needs had changed.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. Staff were provided with appropriate training to help them carry out their duties. Staff received regular supervision. There were enough staff employed to meet people's needs.

People were supported to maintain a balanced, nutritious diet. People were supported effectively with their health needs and were supported to access a range of healthcare professionals.

People using the service and staff felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place.

The organisation had adequate systems in place to monitor the quality of the service. However, auditing systems did not identify the problems we found.

During this inspection we found a breach of regulations in relation to consent, nutrition and dignity and respect. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Procedures were in place to protect people from abuse. However, staff understanding of how to recognise abuse varied and some staff were not aware of the provider's whistleblowing procedure.

The risks to people's mental and physical health were identified and appropriate action was taken to manage these.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

The service had adequate systems for recording, storing and administering medicines safely. However, we found some creams in people's rooms that did not belong to them which created a risk of cross contamination if they were using these.

Is the service effective?

Requires Improvement

The service was not consistently effective. The service was not meeting the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments and Deprivation of Liberty authorisations were not in place as required.

People were supported by staff who had the appropriate skills and knowledge to meet their needs. Staff received an induction and regular supervision and training to carry out their role.

People were supported to maintain a healthy diet. People were supported to maintain good health and were supported to access healthcare services and support when required.

Is the service caring?

Requires Improvement

The service was not consistently caring. Relatives were satisfied with the level of care given by staff, but people using the service gave mixed feedback about the care workers.

We saw varying levels of interaction between care workers and people using the service. People's privacy and dignity was

generally respected and care staff provided examples of how they did this. However, we saw care workers entering people's rooms without knocking first.

People were encouraged to develop their independent living skills and the service provided activities and resources to enable them to do this. People's cultural diversity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were assessed before they began using the service and care was planned in response to these. However, care plans were not always updated to reflect people's changing needs.

People were encouraged to be active and maintain their independence. Staff at the service encouraged people to take part in social events and arranged activities for them to participate in. However, the activities available did not meet the needs of all people using the service.

People told us they knew who to complain to and felt they would be listened
to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. A number of audits were carried out by the registered and other senior managers within the organisation. However, auditing did not identify the issues we found during the inspection.

Feedback was obtained from people through residents meetings. Staff and relatives told us the registered manager was approachable.

Ashmead 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.

The inspection took place on 11, 13 and 14 January 2016. The first day of the inspection was unannounced; the provider knew we would be returning for a second and third day. The inspection team consisted of one inspector, a specialist advisor who was a nurse who specialised in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service. We contacted a representative from the local authority safeguarding team and spoke with six more professionals who worked with the service to obtain their feedback.

We spoke with six healthcare assistants (HCAs), five nurses, the deputy manager and the registered manager of the service. We also spoke with 19 people using the service and five relatives of people using the service. We looked at a sample of 10 people's care records, 10 staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. Comments included "I do feel safe living here", "The building is secure" and "It's a safe place."

The provider had a safeguarding adult's policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated an understanding of how to recognise abuse. However, some staff were not clear on the procedure to follow if they suspected abuse was taking place. For example, we spoke with two nurses and only one could explain that safeguarding concerns were to be reported to the local authority for investigation. However, we spoke with a member of the safeguarding team at the local authority and they confirmed they did not have any concerns about the safety of people using the service.

The provider had a whistleblowing policy in place, but some staff did not know about this and did not understand what whistleblowing involved. Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Staff received emergency training as part of their mandatory training which involved what to do in the event of an accident, incident or medical emergency. Staff told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. For example, nurses and healthcare assistants told us the biggest risk to people's safety was falls. They explained the behavioural signs to look for in people which could indicate that they were at risk of falling and what action they would take to prevent falls. They also correctly explained what they would do if someone had suffered a fall or another medical emergency. There was an emergency call bell in place to alert all staff in case of an emergency and this could be heard by staff in the entire building. We were told that there was a difference in tone between the call bell that people used ordinarily compared with the emergency call bell which people also had access to. We saw call bells were in place in people's rooms and that these were within reach and in working order.

We asked nurses about what they would do in the event of a medical emergency and they explained what training they had done to respond to these situations. Nurses were aware who was for and was not for resuscitation. These details were displayed on the notice boards within the nurse's offices on each floor and nurses also carried a written record of these details on their person.

Initial information about risks to people was recorded in an initial needs assessment. This information was used to prepare care plans and risk assessments in areas including manual handling, skin integrity, falls and continence. The information in these documents included practical guidance for care workers in how to manage risks to people. Risk assessments were reviewed on a monthly basis or sooner if the person's needs changed.

People had equipment in place according to their needs. For example, some people with mobility problems

used hoists and we saw records that demonstrated that these were serviced regularly. However, whilst we were told that slings were for people's individual use, we saw slings in people's rooms that did not belong to them. This meant that people may have been using slings that were not the correct size and therefore a risk to their safety. We reported this to the registered manager and deputy manager and they told us they had taken action to rectify this.

People were involved in decisions relating to risks they wanted to take in order to increase their independence. We spoke with the registered manager and she told us they tried to accommodate people's wishes, particularly with regard to some of the activities they wanted to participate in. For example, some people wanted to go to the local pub on a regular basis, so senior staff ensured the staffing was available to help accommodate this wish, particularly for people with mobility problems.

Staff told us they felt there were enough of them on duty to do their jobs properly. Comments included "Yes, I think there are enough of us working at any time" and "I think there are enough of us on shift."

The registered manager explained that the number of staff members on duty at any time was originally negotiated as part of the initial contract with the Clinical Commissioning Group (CCG). This was reviewed according to the needs of all new people being admitted to the service. If more staff were required this could be renegotiated. If people with higher support needs were admitted, there were provisions in place to allocate an additional one to one care worker for them. Senior staff at the service assessed people's needs on admission to determine whether they could be appropriately cared for. We reviewed the staffing rota for the week of our inspection and this accurately reflected the number of staff on duty.

We looked at the recruitment records for 12 staff members and saw they contained the necessary information and documentation to demonstrate that the provider only employed staff who were suitable to work with people using the service. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms. Records of nurses also included their Nursing and Midwifery Council registration details.

Staff followed safe practices for administering and storing medicines. Medicines were delivered on a monthly basis for named individuals by the local pharmacy. Medicines were stored safely for each person in a locked cupboard and we saw the temperature was controlled, monitored and recorded on a daily basis. The temperature was at a safe level on the day of our inspection.

We looked at the controlled drugs cabinet. We saw that controlled drugs were stored in an appropriately constructed safe which was within another cabinet which was also locked. These medicines were recorded in a separate book and the amounts were checked twice a day by two nurses. We did a physical count of the controlled drugs and saw the amount recorded tallied with the amount available.

We saw examples of completed medicine administration record (MAR) charts for 10 people for the month of our inspection. We saw that staff had fully completed these. We checked the medicines available for them and counted the amounts stored. We saw these tallied with the records kept.

MAR charts also included details of creams people were using. We checked some of the creams in people's rooms. We saw that some creams did not include the date of opening or expiry date and some creams were in other people's rooms. This meant there was a risk of cross contamination from people using creams which did not belong to them.

Individual protocols were in place for some "as required" (PRN) medicines, but we did not see a protocol in

place in one chart for a person's PRN medicine. We spoke with the registered manager and deputy manager about this and were told this would be rectified as soon as possible.

We saw copies of monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify any issues.

Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines.

We recommend that the provider seeks advice from a reputable source about improving the knowledge of staff in relation to safeguarding and whistleblowing procedures.

Requires Improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and found that the provider was not meeting the requirements of the MCA. Staff had received MCA training, but most were not able to demonstrate that they understood the issues surrounding consent. When we explained the meaning of capacity, staff told us they had not had any concerns about people living at Ashmead Care Centre. Some staff were unable to explain what they would do if they suspected someone was making a decision without having the capacity to do so.

We saw examples of people's rights not being observed under the MCA. For example, we saw care records of three people who were deemed to have fluctuating capacity who had bed rails in place. We did not see evidence of this decision being made with their consent and there was no evidence of a mental capacity assessment, best interests decision or DoLS authorisation in respect of this.

We saw on some units within the building that exit was via a key pad. This meant that people were not able to leave the building without asking staff for the code. We observed one person telling staff that they wished to leave. Care workers spoke with this person, but we observed that they did not leave the building and were not assisted to do so. We saw numerous examples of mental capacity assessments in respect of people's decision to leave the building within their files, including the person we observed requesting to leave. All these assessments concluded that people did not have the capacity to leave the building on their own. However, there was no evidence of a best interests decision or a DoLS authorisation allowing staff to restrict their movement.

We also saw numerous examples of documentation in people's care records being signed by their next of kin. This included advance care plans which recorded people's end of life wishes and consent forms for the taking of photographs as well as care plans. However, there was no indication on the documentation as to whether the next of kin had Power of Attorney in respect of the person's health or welfare making them legally able to make decisions in their relative's best interests. We queried this with senior staff during our inspection. We were given one document which authorised the next of kin to make decisions regarding the person's property, but not for health or welfare decisions.

The above issues relate to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where monthly monitoring was required to ensure people's health needs were met, for example monthly weight checks, we saw this was done and recorded. We saw some examples of food and fluid charts being used for people who required close monitoring due to risks associated with their nutrition intake, although not all of these were fully completed. Although we saw fluids were regularly offered and available throughout the day, we could not be fully assured that people's fluid and nutrition intake was adequately monitored as a result of these incomplete records. This may have put people at risk of their nutritional needs not being met as staff would not always have accurate information to hand about people's fluid and food intake and therefore would not know whether they needed to encourage further intake to meet their needs.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food available at Ashmead Care Centre. Comments included "The food is good" and "The chef is excellent." We spoke with the chef about the food available. They explained that they obtained feedback about the food from the care workers who relayed people's views. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and we saw two different choices of food were offered for every meal. For example on the first day of our inspection we saw lamb curry and rice was available or cauliflower and cheese for lunch. We sampled the lunch on the first and second days of our inspection. Food was appetising, of a good portion and served at the correct temperature.

People were encouraged to eat a healthy and balanced diet. People's care records included information about their dietary requirements which included details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. These included nutrition screening tools which were used to determine whether people were at risk of malnutrition. Based on this, people were monitored further or referred to specialists such as Speech and Language Therapists or dietitians. There was evidence that the provider acted upon the guidance received.

We asked the chef how they provided food for people's varying health needs. They told us what people's specific requirements and allergy information were, but also showed us a file which contained this information, which they had to hand. They told us that they worked with the dietitian to prepare food that met people's nutritional needs and this included fortifying meals.

People told us staff had the appropriate skills and knowledge to meet their needs. People said, "They know how to do their jobs" and "They try to get everything done." The registered manager told us, and care workers confirmed, that they completed training as part of their induction as well as ongoing training. Records confirmed that all staff had completed mandatory training in various topics as part of their induction. These topics included safeguarding adults, medicines administration and dignity. There was also more specialist training available where required, for example specialist dementia training. We saw the home's training matrix and saw that people had completed training in the mandatory topics within the last two years.

The registered manager told us that they discussed person centred care during their induction. Care workers told us these discussions focussed on how to deliver a service based on people's individual needs. They gave us practical examples of how people's individual choices were at the centre of the work they did and were able to describe people's health conditions, how these manifested themselves as well as people's habits and routines. Care workers also demonstrated knowledge of people's relatives and their life histories.

Care workers confirmed they could request extra training where required and they felt that they received enough training to do their jobs well. One care worker told us, "We get plenty of training. It's ongoing. Face to face and online training."

Most staff told us they felt well supported and received regular supervision of their competence to carry out their work. We saw records to indicate that staff supervisions took place every three months. We were told by the registered manager and care workers that they used supervisions to discuss individual people's needs as well as their training and development needs. The registered manager told us annual appraisals would be conducted of care workers performance once they had worked at the service for one year, but we were told that senior staff were behind in their completion of this year's annual appraisals. We were shown a plan of scheduled appointments with staff for the completion of this year's appraisals.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about peoples' health needs. When questioned, care workers demonstrated they understood people's health needs. For example, all care workers told us how people were feeling on the days of our inspection and if they had any specific health conditions. The service had close links with the local GP who visited regularly.

Requires Improvement

Is the service caring?

Our findings

People who used the service gave mixed feedback about the care they received. Comments included "Some staff treat you nicely, others ignore you", "I'm treated like a Queen", "I'm very well treated", "Some [staff] are very good, but some are unhelpful" and "Staff try to be caring but they don't have enough time."

We found that staff did not always respect people's privacy. People we spoke with told us their privacy and dignity was respected and one person told us, "They do respect me." Care workers explained how they promoted people's privacy and dignity and comments included "I always knock on their doors", "I always cover the bits that don't need to be exposed" and "I make sure the door is closed and the windows are covered. I also explain what I'm going to do before I do it." However, we observed other staff entering people's rooms without knocking or introducing themselves first which did not respect people's right to privacy.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with gave good feedback about the care workers. Relatives told us, "We are very happy with [our family member] being here" and "The staff give me the feeling they look after my [family member] as if she was their Mum."

Staff demonstrated a good understanding of people's life histories. Senior staff and care workers told us they asked questions about people's life histories and people important to them when they first joined the service, however, we saw varying levels of detail recorded in people's care records. Staff members we spoke with gave details about people's lives and the circumstances which had led them to using the service. They were well acquainted with people's habits and daily routines. For example, staff were able to tell us about people's likes and dislikes in relation to activities as well as things that could affect people's moods.

Care records demonstrated that people's cultural and religious requirements were considered when people first started using the service. We saw initial assessments included details of people's cultural and religious requirements.

People we spoke with told us they were able to make choices about the care and support provided and told us their wishes were respected. One person said "If I don't want to do something they leave me alone." Staff told us they respected people's choices and encouraged them to be as independent as possible. For example one nurse spoke passionately about the need to offer choices to people in all aspects of their lives. They told us "Control is independence and independence gives people confidence." They told us they offered people choices with what clothes they wanted to wear, what food they wanted to eat and encouraged other staff to do the same.

We saw varying levels of interaction from care workers during our inspection. Some interactions we observed and conversations we overheard demonstrated that staff knew people well and were on friendly

and familiar terms. For example, we overheard one conversation between a care worker and a person using the service about a shared sporting interest and the care worker read this person details about the sport from the newspaper in a lively way. However, we also observed two care workers not engaging with people at all, despite providing them with one to one care which meant people were not always provided with social interaction and reassurance from staff when being supported.

Requires Improvement

Is the service responsive?

Our findings

Relatives we spoke with told us they were involved in decisions about the care provided and that they were aware of their relative's care plan. A relative told us, "It's all on record" when queried about whether they were involved in their family member's care plan and another relative told us staff phoned them periodically to go through the care plan.

People were encouraged to express their views and be involved in decisions regarding their care. People were given information when first joining the service in the form of a 'service user guide' which included details about the service provided and the core values of the service. Residents meetings and additional relatives meetings were held every three months. We saw minutes relating to these meetings and saw various topics were discussed and actions had been taken to rectify issues raised. Care records also included details about people's views and staff explained that they prioritised people's choices in relation to their care. For example care workers gave us numerous examples of how they respected people's choices in their daily lives. One nurse told us "I never assume what people want. I always ask them."

People's needs were assessed before they began using the service and care was planned in response to these. Assessments were completed in various aspects of people's medical, physical and social needs. The care records we looked at included care plans in areas including nutrition, continence and moving and handling which had been developed from the assessment of people's individual needs. Care records showed staff considered people's views in the assessment of their needs and planning of their care. Care plans included details about people's preferred routines, habits, likes and dislikes in relation to a number of different areas including nutrition and activities. People's progress was reviewed at meetings with their key worker every month. People's views were then used to formulate future goals.

Most care records we saw were updated in accordance with people's changing health needs. However, we saw three specific care plans which had not been updated as required when people's health needs had changed. For example, one person had been suffering from frequent urinary tract infections, but we did not see appropriate advice detailed in how to manage this. Another person's care record stated that they were continent, yet their monthly review stated that they were now incontinent. There was no update to their care plan in how to manage this although staff were aware of the change in this person's condition.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. We saw from people's care records that people's likes and dislikes in relation to activities were recorded. However, we received mixed feedback about the activities on offer. Comments included "[There is] no stimulation", "I like ball games" and "I'm not interested in activities."

The service had four activities coordinators and we spoke with one on the first day of our inspection. They were aware of people's feedback and had made detailed notes of people's preferences in relation to activities. They told us they would use this feedback to make changes to next month's activities programme. They told us "Physical activities seem to be more popular, so I'll make sure we do more of that next month."

There was a monthly plan of activities which was displayed on a notice board for residents which included one morning activity and one afternoon activity. Types of activities on offer were cake decorating, watching movies and playing games with a ball or parachute and skittles among others. Outings were also arranged and these included a weekly visit to the pub which some people preferred. We saw from the activity coordinator's notes that people had different interests and their varying levels of cognition meant different types of activities were suitable for different people. We were told that the group activities aimed to cater to a broad range of needs, but would inevitably not be suitable for everyone. The activities coordinator told us "I try to go to everyone. Some people are bed bound so I ask them what I can do for them to keep them engaged. Some people want to be read to, some people want a chat and others don't want to be involved at all. I respect everyone's wishes, but will always double check with people in case they change their minds or in case they decide they want to do something different."

The service had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We saw records of complaints and saw these were dealt with in line with the provider's policy. Care workers we spoke with confirmed that they discussed people's care needs in their supervision sessions and their team meetings. They told us if there were any issues or complaints they would discuss them at these times.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems to monitor the quality of the care and support people received. We saw evidence of numerous audits covering a range of issues such as people's weight, pressure sores, medicines, falls management and infection control. These included an action plan. A further quality inspection was also conducted by senior staff within the organisation on a quarterly basis which assessed compliance with CQC regulations. Most audits appeared to be thorough, however, we noted that auditing of compliance with the Mental Capacity Act 2005 did not identify the issues we found because this did not include a check of documentation. In addition, the provider had failed to identify other issues we identified during our inspection such as the infection control risk posed by use of creams for individuals, the incomplete food and fluid charts, care plans that had not been updated and staff behaviour in relation to the privacy of people using the service.

The service had an open culture that encouraged people's involvement in decisions that affected them. Staff and relatives told us the registered manager was available and listened to what they had to say. Comments included "She is very approachable. She has time for you" and "She is nice. She does listen." We observed the registered manager interacting with people using the service throughout the day and conversations demonstrated she knew people well and spoke with them regularly. We observed people approaching the registered manager and she responded to their queries straight away.

Staff told us they felt able to raise any issues or concerns with the registered manager. One member of staff told us, "She is a strong leader. She is good." The registered manager told us staff meetings were held every two months to discuss the running of the service. Staff told us they felt able to contribute to these meetings and found the topics discussed were useful to their role. We read the minutes from the most recent staff meeting. These showed that numerous discussions were held with actions and identified timeframes for completion.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was received during 'residents' and separate relatives meetings. People told us they found these meetings helpful and felt comfortable speaking in them. We were told by the registered manager that if issues were identified, these would be dealt with individually and we were given an example of when this had happened.

We saw records of complaints, and accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor trends or identify further action required and we saw evidence of this. They told us all accidents and

incidents were also reviewed by senior staff at the provider's head office. Staff at the head office monitored incidents for trends and made further recommendations where required.

Information was reported to the Care Quality Commission (CQC) as required. We spoke with a member of the local authority and they did not have any concerns about the service.

The provider worked with other organisations to ensure the service followed best practice. We saw evidence in care records that showed close working with local multi-disciplinary teams, which included the Behaviour and Communication Support Services, the GP, Trinity Hospice and local social services teams. We were told by a member of Trinity Hospice that the service was working within the Gold Standards Framework. This meant that staff were working to improve the quality, coordination and organisation of care for people nearing the end of their lives and were working within a framework with staff from Trinity Hospice to achieve this. We spoke with seven health and social care professionals and they commented positively on their working relationship with staff at Ashmead Care Centre.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that service users were consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 in circumstances where service users may have lacked capacity to consent to decisions regarding their care (Regulation 11(3)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not mitigate the risks of service users nutritional and hydration needs not being met.