Ashtonleigh Homes Ltd

Ashton Grange Nursing & Residential Home

Inspection report

3 Richmond Road
Horsham
West Sussex
RH12 2EG

Tel: 01403257263

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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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 2 and 9 October 2018. The first day was unannounced. Ashton Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashton Grange is registered to provide nursing, care and accommodation to 31 people. There were 29 people living in the service when we visited. People cared for were mainly older people who were living with a range of care needs, including arthritis, diabetes and heart conditions. Most people were also living with dementia, some of these people could show behaviours which may challenge others. Most people needed support with their personal care, eating, drinking or mobility.

Accommodation was provided over two floors of a turn of the century house, which had been extended to the rear. The service was situated in a quiet residential street in Horsham.

The service had a registered manager in post. 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 is Ashtonleigh Homes Limited who own another home in the area. The owner also provided a service in two other homes; these are registered as different legal entities.

The service was last inspected on 26 January 2016. It was rated as good at that inspection.

At this inspection, we identified a wide range of areas which needed to be addressed and the service is now rated as requires improvement.

The provider's own quality audit systems had not identified some areas or ensured appropriate action was taken before our inspection to reduce people's risk. Similar issues were identified at the other three services owned by the provider. Matters identified at this service included making sure appropriate standards of hygiene and infection control were maintained and certain aspects of medicines care and treatment were in place. The provider had also not ensured all people who had difficulties with consenting to care and treatment had relevant best interest decisions and Deprivation of Liberties safeguards (DoLS) considered. People had care plans but the provider had not identified in their quality audits that they did not consistently reflect their needs, were not always reviewed when necessary and were not always being followed by staff. National guidelines in relation to relevant areas such as diabetic care and prevention of pressure ulceration were being followed and reflected in people's care plans.

We recommend the service follows NICE guidelines on care planning to support people who are living with diabetes.

People received a mixed approach from staff, some of whom did not show a kindly, caring approach. This

lack of care was also shown at mealtimes where some people were not always attended to in the way they required, while other people received the assistance they needed. Some people who remained in their rooms were supported in a functional way by brief, infrequent visits. Other staff supported such people in a kindly understanding way. People who went to the lounge were supported by staff who engaged with them in an effective way.

There were enough staff on duty. Staff had been recruited in a safe way. Staff told us they were supported by the provider, including through the training they received. All staff were aware of their responsibilities in relation to ensuring people were safeguarded from risk of abuse.

Staff ensured the safety of people in some areas, including supporting people who needed assistance to move about in a safe way and when supporting them with certain aspects of their medicines care and treatment. People told us relevant external healthcare assistance was requested when necessary.

People and staff told us they felt supported by management. People and their relatives said they were confident if they raised any complaints that they would be listened to and action would be taken.

The provider had acted to ensure people's safety in some areas, for example by developments in fire safety precautions by the installation of a sprinkler system. They also had plans for up-grading and making improvements to the home environment.

We identified five breaches in the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

People's safety from some risks was not consistently ensured.

Effective standards of hygiene were not always maintained.

Some arrangements for the safe management of medicines had not been identified. Other systems were safe.

People were supported by staff who knew how to safeguard them from risk of abuse.

There were enough staff, who had been safely recruited, to support people.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act (MCA) and DoLS were not always being followed.

Some people did not always receive the support they needed with their meals.

National guidelines were not always followed in relation to some people's treatment needs.

Staff were supported, both through training and supervision.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff did not show a caring, empathetic approach to people.

Some people's dignity was not consistently supported.

Other staff showed a kindly, caring to people and supported people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always clearly set out how they needed to be cared for. Some staff did not follow people's care plans.

People did not always receive continuity of care from the same members of staff.

The provider's own systems for addressing people's concerns and complaints were followed.

Is the service well-led?

Inadequate

The service was not always well-led.

The audits of service provision did not consistently ensure people received a safe, quality service. Some issues had not been identified during audits, so action had not been taken to address relevant areas.

The registered manager was not always available to manage the service because they were supporting another service owned by the provider.

People and staff commented positively on the service's culture and said they felt supported by management.

Ashton Grange Nursing & Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 2 and 9 October 2018. The first day was unannounced. The inspection was undertaken by an inspector 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.

Before our inspection we reviewed the information we held about the agency, including the previous inspection report. This enabled us to ensure we were addressing any potential areas of concern. The provider had sent us an information return (PIR) in which they outlined how they ensured they were meeting people's needs and their plans for the next 12 months. As part of the inspection, we reviewed the PIR. We also reviewed other information about the service, including safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority before and after the inspection, to receive their comments and discussed some matters with the Fire and Rescue service after the inspection.

We met with 16 people and four people's relatives. We spoke with eleven staff, including the deputy manager, a registered nurse, care workers, domestic and catering staff and activities workers. We also met with the registered manager and two directors for the provider.

We 'pathway tracked' 6 of the people living at the service. This is when we look at people's care documentation in depth, obtain their views on how they found living at the home and make observations of the support they were given. It is an important part of our inspection, as it allows us to capture more

detailed information about a sample of people receiving care.

During the inspection we reviewed other records. These included six staff recruitment records, training and supervision records, medicines records, risk assessments, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At the last inspection, this key question was rated as good. At this inspection, we found the rating had deteriorated to requires improvement.

Two people had urinary catheters. Manufacturers' guidelines state that catheter leg drainage bags need to be changed between every five to seven days. This is because both more frequent changes and less frequent changes increase the risk of infection for the person. Neither of the people had any information in their care plans about which day of the week their catheter leg drainage bags were to be changed. When we asked staff, they could not tell us this information. One of these people's records indicated their bag was changed more frequently than every five days, however staff we spoke with were unclear about this record and were unsure if it related to changing the person's overnight drainage bag or their leg drainage bag. The lack of clear procedures about changing people's catheter leg drainage bags had the potential to put people at risk of infection.

The National Institute for Health and clinical Excellence (NICE) set out guidelines about prevention of pressure damage. These state that because pressure sores can last for an extended period, may be very painful and can be a source of infection, the emphasis must always be on their prevention. We met with a person who told us they had had pressure sores in the past, they remembered how painful they were, so did not want to have any more. We discussed the needs of three people who had been assessed at being at high risk of pressure damage with staff, and reviewed their records.

We asked five staff about these three people's risk of pressure damage. Two members of staff said they did not think these people were at risk of pressure damage. On the first day of the inspection, one of the three people assessed as being at high risk of pressure damage was lying on their back in bed each time we visited them. We asked staff about what they did to reduce this person's risk. Staff gave us differing responses. For example, one member of staff told us the person moved themselves independently in bed, another member of staff told us the person tended to toll themselves back onto their back and another that they only liked to lie on their back. The person's care plan only documented staff were to 'make positional changes regularly if unable to do so independently,' with no more information on how frequently this was to be done, how the person preferred to lie, the extent to which the person was able to change their position independently or needed support to remain in a different position. The provider had not taken appropriate action to ensure this person's risk of pressure damage was reduced.

Some people living in the home tended to walk about the building. These people were sometimes unaware of where they were or of any risks that may be presented. For example, on the morning of the first day of the inspection one of these people sitting comfortably in the easy chair in another person's room. In the afternoon, we observed one of these people in a person's room in a different area of the home. They had picked up the person's cup and was drinking from it, unaware it was someone else's cup. Staff confirmed these people freely walked about the ground floor and they monitored their safety as much as they could by observing where they were, but because they were free to walk as they wanted, they could end up in a range of different parts of the building. While the service used stairgates to ensure the privacy of people from being

disturbed by these people, they had not ensured the safety of all relevant areas. On both days of the inspection, the door to the conservatory store room beyond the dining room was unlocked. It included items which may present a risk, like a clothes press. There was a door beyond this room to a narrow, outside paved area. This door was also not secured. This area also had equipment, such as a ladder, which could have presented a tripping injury in this narrow area. We asked for an environmental risk assessment for this area; one was not in place. Because these areas were not secured to prevent these people from gaining access, the potential risks to them had not been reduced.

A range of areas, furnishings and equipment in the home were not clean on the first day of the inspection. This included among other examples, bed rail covers, wheelchairs used for moving different people about the home and one assisted bathroom. We showed these and a range of other matters, such as clinical waste bins which were not functioning to the registered manager at the end of the first day of the inspection. All had been addressed by the second day, however these issues had not been identified and rectified before we noted them.

Some areas relating to medicines had also not been identified and addressed before the inspection. This included no evidence of people who needed regular injections of insulin having the sites of their injections rotated to reduce risk of tissue damage and ensure effective uptake of insulin. One person's medicines administration record (MAR) relating to their insulin prescription had been changed by hand. The changes on the MAR had not been signed and counter signed by a member of staff to verify this was the prescriber's instructions. The service supported people who were prescribed 'as required' (PRN) medicines. Where this was the case, they kept a separate PRN record which outlined relevant information such as when the person was to be supported PRN medicines and how often this was to take place. Information in people's PRN records and on people's MARs did not agree. For example, one person had a PRN record that they were prescribed a specific painkiller which was not documented on their MAR, while another person had a painkiller documented in their MAR which did not have a PRN record. These and other matters were addressed by the second day of the inspection, however they had not been identified and relevant action taken before the inspection.

The provider had not ensured safe care and treatment was provided to people where relevant. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider ensured people's safety in other areas. We observed staff supporting people to move. They did this in a safe way, using equipment safely and appropriately when necessary. Staff who used equipment to support people to move worked well together as a team. Staff told people what they were going to do to support them throughout the time they were helping them. Staff also encouraged people in being as independent as possible, depending on the type of assistance each individual needed. One member of staff told us in detail about how they supported one person to move using specific equipment. What they told us was fully reflected in the person's moving and handling assessment and care plan.

Records relating to supporting people with their catheters themselves were clear and indicated the catheters themselves were being changed in accordance with the person's care plan and national guidelines.

All other areas relating to medicines were safe. The registered nurse who supported people with taking their medicines did this in a safe way, checking the MAR and the medicines containers before giving medicines to the person. The registered nurse remained with the person to check they had swallowed their medicine, before they signed the MAR. We saw the registered nurse giving one person some eye drops. They did this in a sensitive way. This included ensuring the person was left with a fresh tissue afterwards in case they should

need it. All medicines were securely stored and in an orderly way.

Action to ensure people's safety had been taken in other areas. The registered manager had identified that due to changing dependency of people living in the home, there was a need for additional staff to ensure the safety of people at night. The registered manager confirmed that after they had presented their evidence about this to the provider, the provider had allowed an additional member of staff to be placed on night duty to ensure the safety of people at night.

People told us they felt safe at the home. One person told us, "Yes I think I am safe, they look after me fairly well." One person's relative told us, "I think she is safe here, they have been very good with her." All the staff we spoke with, including ancillary workers had a clear understanding of their responsibilities for safeguarding people from risk of abuse. Staff also knew how to take matters further. One ancillary worker told us, "I'd report it straight on if I need to." The home maintained records of any safeguarding alerts made, together with evidence of liaison with the local safeguarding teams.

Everyone we spoke with, including staff, told us they felt there were enough staff to support people. People and staff also told us there was a good ratio of staff to people, and this included ancillary staff. We saw at lunchtime that there were enough staff on duty to support people who needed help with getting into the dining room and people did not have to wait for long periods at that time, until they received the assistance they needed.

The home had safe systems for the recruitment of staff. We looked at records of six staff, some of whom had been recently been employed. These showed prospective staff were assessed for their suitability. All staff files included key documents such as a full employment history, at least two references and a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service. Records showed registered nurses had their registration with the Nursing and Midwifery Council (NMC) verified and their continued registration was regularly checked.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, this key question was rated as good. At this inspection, we found the rating had deteriorated to requires improvement.

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

Where people had been assessed as not having capacity in certain areas such as the use of equipment like bed rails or stairgates, best interests' meetings had been held, including consent from their representatives. However, where people were assessed as not having capacity to consent to such matters, the service had not considered their capacity to consent to other matters like insulin injections or in the use of urinary catheters. These matters were in the process of being actioned by the second day of the inspection. However, they had not been identified before our inspection and appropriate consents to care and treatment sought.

This is an area which requires improvement.

The registered manager maintained full records for all people who were subject to a DoLS. These were available for all staff to view if they needed to on the home's computerised records system. One person who was heard to repeatedly call out that they wished to go home throughout both days of the inspection had a DoLS about the matter.

Ashton Grange is a care home which supports people who were living with dementia. However, people who were living with dementia were not always supported in choosing their meals in line with current best practice guidelines. Staff offered people choices meal verbally, some time before meals. For example, we heard one member of staff during the morning asking a person if they wanted "soup" or "sandwiches" for supper. The member of staff also did not explain to the person what the flavour of the soup was or type of sandwiches, which would have supported the person in making a choice. Before lunch, one person asked what was for lunch, the care worker they were with did not reply. The person asked the activities worker who said they did not know. At lunchtime, there were some pictures of meals on a notice board on the wall close to the servery, but there were no other pictorial or written aids for people, to support them in making meal choices. The service did not use other commonly used ways of supporting people who were living with dementia with making meal choices such as showing people what the choices were when they were at table.

We observed a mealtime, staff varied in how they supported people. On two occasions, the member of staff assisting a person stood up to assist them. This made the support they were giving the people functional rather than person-centred. One care worker who did sit with a person was being repeatedly distracted by other matters in the dining room and did not give their attention to the person they were supporting. One person stopped eating their lunch and became uncertain of how to use their fork. The care worker attempted to help the person by wrapping the person's hand round their fork. When the person did not respond to this, the care worker stopped helping the person, leaving them with their uneaten food.

Where people chose to eat in their own rooms, people also received a varied approach from staff. One person's meal was put down in front of them and they were left on their own in their room without further support. Fifteen minutes later, their food was still there, untouched. Another person was left with their meal placed on their bed table. This was at a higher level than their eyes, so the person could not see their meal, which remained untouched.

We discussed our findings with the registered manager and discussed the range of guidelines which are available on supporting people who live with dementia in making choices about what they eat. They said they would consider such guidelines in the future. They told us their emphasis had always been on supporting people who needed complex support at mealtimes. They would review how they supported people who had less intensive support needs. They said where people had not eaten their own meals, they were always offered snacks such as crisps for them to eat when they wanted.

The provider was not consistently ensuring the nutritional needs of people were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On other occasions where people needed assistance from staff to eat their meals, staff sat down with people to make it a social occasion. Other staff were good at supporting people, making eye contact and talking to the person they were supporting with their meal, not overloading the spoon and taking their time to ensure that the food offered was swallowed before offering more.

Some people received sensitive support from staff. One member of staff helped a person to adjust the height of their bed so they could support themselves independently, another checked with a person that they were happy with how they were positioned in bed in relation to their meal, before they left them. One person said they did not like what they had been given to eat and the member of staff went to get the person another choice, in a friendly and helpful way.

There was a varied response when supporting people who were living with additional healthcare needs. We looked at records of two people who were living with diabetes. Their care plans did not follow NICE guidelines on supporting people who are living with diabetes. One person's care plan documented two different blood sugar levels in relation to low blood sugar levels, the former level was below levels set out in NICE. Neither care plan directed staff when and how often a person's blood sugar levels should be re-checked if they showed low or high blood sugar levels. Nether care plan included other relevant matters such as regular checking on injection sites for any changes in the skin. Both care plans outlined general symptoms for low and high blood sugar levels not the symptoms shown, or experienced, by the person themselves if they had low or high blood sugar levels.

We recommend the service follows NICE guidelines on care planning to support people who are living with diabetes.

In other areas people told us staff responded well if a person needed support from external professionals.

One person's relative told us, "The nurses are very good at picking up on things if they feel something isn't right. They get the doctor in straight away and are always very good at letting me know what is going on." We heard a registered nurse discussing a person's eye condition with them and their relative and asking if they wanted a referral back for medical advice. One person had all of their fluids and nutrition by a percutaneous endoscopic gastrostomy (PEG). They had a clear care plan which staff knew about, and their records showed it was being managed in accordance with current guidelines on PEGs.

Staff commented positively on the support given to them through the home's training and supervision programmes. One care worker told us, "I've had lots of training here," another, "I've done all the training available," and an ancillary worker, "The training here's okay." One newly employed care worker told us their induction had been, "Very useful." One newly employed registered nurse told us they had never worked unsupported during their induction. Staff told us they had regular supervision and annual appraisals. One care worker told us, "Any concerns, I speak to my manager, we meet once a month," One registered nurse told us they were supported by management in going on clinical training, as well as more general training relating to care.

The registered manager had a training plan which showed all staff were regularly trained in key areas such as moving and handling, safeguarding and equality and diversity. The manager also had a record which showed all staff received regular supervision. She said she personally reviewed all supervision records so she could identify any areas for action in training. One of the directors told us the provider was keen to promote training opportunities for staff, to ensure they had the necessary skills to perform their roles. For example, they had during the last year ensured all relevant staff had been trained in supporting people who showed challenging behaviours.

Ashton Grange was situated in a large town house, which had been extended to the rear. The rooms in the older building were all large, but other rooms were smaller and not all had en-suite facilities. The rear corridor was narrow and we saw staff being careful when they supported people using equipment in this part of the home. We discussed the home environment with the provider. They were aware some of the facilities needed upgrading to suit the environmental needs of more disabled people. They outlined their future plans for extensive development of the home to meet the needs of people into the future.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, this key question was rated as good. At this inspection, we found the rating had deteriorated to requires improvement. One person told us they did not like living in the home, however another person told us, "Yes, they are mostly kind." One person's relative told us, "The care is very good, they have all been very kind to her" and another, "It's good in the way they really do care." However, despite some positive comments we found the provider was not consistently ensuring a caring service was provided to people. We saw mixed responses from staff. Some were very positive others were not so positive.

People who needed support did not always receive it in a sensitive way. One person had dropped food and drink on their clothes when they were eating in bed. The member of staff who came to them did not ask if they would like to have their clothes and bedding changed and left them as they were. One person told us they had dropped some tea on their nightie and would like it changing, their call bell had been left by staff pinned in a position where, due to their disability, they could not quite reach it.

People who showed anxiety did not always get consistent support from staff. For example, one person showed anxiety about when their relative would be visiting. The member of staff with them only briefly told the person when their relative usually visited, with no further information or reassurance, which did not appropriately support the person who was living with advanced memory loss.

Staff did not always support people appropriately. One member of staff described people by their room numbers to another member of staff, not by their names. One person who remained in their room forgot to drink their mid-morning drink. The member of staff who came to take their cup away told them it was cold, so they were taking it away. They did not offer the person any other support such as asking them if they wanted another warm drink. One person was crying out in a distressed way throughout one morning. The member of staff who went to check on the person showed a functional approach, asking them if they wanted a drink or the television on; they stayed with for under a minute. The member of staff did not try other approaches, such as sitting with the person for a period, supporting them or showing empathy. When the member of staff left, the person began calling out again.

Staff did not always involve people in their care or seek their consent with how they were supporting them. At lunchtime only one member of staff asked people's permission before putting clothes protectors on them, other staff routinely put clothes protectors on people, without any attempt to ask them if they wanted them to do this or giving explanation of why they were doing it.

Several people remained in their rooms all the time. Many of these people spent most of their day alone, except for task-led visits from staff providing drinks or meals. Visits to people were frequently brief and functional, not empathetic. For example, one of the people we visited, clearly enjoyed having brief chats about matters such as objects which were familiar to them in their room and the clothes they wore. They found a difficulty in concentrating for long conversations but enjoyed such brief, supportive interactions. All the visits to the person related to functional matters such as if they wanted a drink. Staff did not use such interactions as an opportunity to chat with the person about other matters, but went away as soon as they

had received an answer to their question. Another person was confused about time and place, however they could talk about a range of matters for short periods of time. Again, staff interactions were functional, not empathetic and were not used to orientate the person to matters which might support them, such as what the weather was like outside or items in their room which may have been of interest to them.

The provider had not ensured all people were consistently treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Such attitudes were not shown by all staff. Staff sought consent from people in some areas, for example when putting their feet on wheel chair foot pedals. One person began to cry in the dining room. The member of staff with them put an arm round them and give them a hug, before offering to get them a drink. Another member of staff took their time to gently reassure a person about when their relative would be visiting, calming them by their response. Another member of staff spent time in the lounge in the afternoon sitting and talking to different people individually, devoting a little bit of their time to being there just for that person, without distraction.

One member of staff showed a caring, empathetic approach towards one person who lived with a wide range of disabilities, who remained in their room all the time. Another member of staff was supportive in a friendly and approachable manner towards a person who walked around the home a lot, walking with them, listening to what they said, taking the time to be kindly and helpful to the person.

Some staff were kindly and supportive in approach to people who remained in their rooms all day. One member of staff went into one distressed-sounding person, gently saying, "How are you today," showing an empathetic response. Two staff went to support a person who remained in their room all the time, they were kindly and friendly to the person, explaining how they were going to support them and encouraging the person to interact with them.

Some people had been supported to personalise their rooms with possessions that they had brought with them when they moved in. Several rooms showed photos and pictures that were important to the person who lived there. Where people shared a room, written consent for this had been sought from people's representatives. The service ensured all people's clothes were appropriately marked before they went to the laundry, so people had their own clothing returned to them after laundering. This shows a sensitive approach by the service to people living with dementia who may not always be able to recognise their own clothing.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection, this key question was judged to be good. At this inspection, people's relatives told us the service was responsive. One person's relative told us, "They manage her very well even though she is often difficult," another, "I feel she is in good hands," and another, "They are good at keeping me informed and involving me in what is happening." However, despite these comments, we found the rating had deteriorated to requires improvement.

We looked at people's care plans and at how staff responded to people. One person remained in their room all the time. They shouted out repeatedly, including banging on their table. We asked staff if this was what the person usually did. They all confirmed it was. The person's care plan documented they were confused in time, place and person. It also documented they needed 'a lot of encouragements and guidance' and that they tended to shout, 'out of frustration'. The intervention documented was to go and ask them if they were all right and needed any support. Staff did go into the person at times, they stayed for under a minute on each occasion and were functional in their approach, only asking if the person if they wanted a drink or something to eat. As soon as the member of staff left the person, they began to show the same behaviours as before. This means what was outlined in the person's care plan and staff response to the person were clearly not being effective to support the person in relation to their dementia care needs. Both the care plan and staff response showed a passive, not proactive response to supporting this person.

Staff did not respond appropriately to people in other areas. One person did not take any food or fluid in by mouth and their needs were met by a PEG. We asked staff how they supported the person with oral care. We received a variety of responses. One member of staff told us oral care was not possible for the person because they became so agitated, it could affect their other health conditions. Another member of staff told us they cleaned the person's teeth twice a day with an electric toothbrush and the person was happy for them do this. Another member of staff said they asked the person if they wanted month care and sometimes they refused and at other times they agreed. The person's oral health care plan documented the person's oral health was to be 'attended to' as the person was not able to do so themselves. It did set out the person's reluctance to have their mouth touched but did not reflect the range of responses we were told by staff. This means the person was at risk of not receiving a consistent approach from staff.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. The service cared for one person whose first language was not English. Staff all confirmed this person could be variable in their ability to speak and read English, depending on how they were that day. When we looked in the person's room, we saw there was a list of common phrases translated from the person's own language on the wall. However, all other signs in the person's room, such as where their toilet was and important fire safety information remained in English and were more prominently displayed than the list of translated phrases. Although the person moved freely about the home, no other relevant signage for areas like toilets had been provided in their own language to support the person.

People did not receive consistent care in other areas. Three members of staff told us a person had visual difficulties. They said, due to this the person was given all their drinks in red cups, this helped them in being independent with drinking because they found red cups and plates easier to see. Despite this, while the person was given their lunch on a red plate, with a drink in a red cup, later on in the day the person was been left with a drink in a white cup and later on in a blue cup which indicated staff were not consistently supporting the person's independence with their visual disability.

One person remained in bed all of the first day of the inspection. The person's social isolation risk assessment documented they were at risk and staff were to provide 'T.V/radio;' it did not document which programmes they liked. Their care plan documented they liked music, specifying a particular band. It also documented they liked to talk 'about their profession' but did not give any information on what their profession had been. Staff knew differing information about the person's likes, one member of staff told us the person liked to talk about motorbikes and tennis, another member of staff told us the person preferred classical music. One news radio station played in their room all of the inspection day, even when the person was asleep. The person's information did not include enough information on how they wanted to be supported and staff were inconsistent in approach to engagement with the person.

Because of these discrepancies in approach, we asked staff how they found out about people's individual needs. They told us all people had a care plan. Care plans were kept on computers, and they could access them when needed. We asked care workers how often they reviewed people's care plans. They told us care plan reviews were completed by the managers and registered nurses, not care workers. One care worker told us they did not, "Have much time" to read people's care plans, another that the information they needed to care for people was given to them verbally during shift handovers.

Staff told us they were allocated what they were to do by task at the start of each shift, for example some care workers would be allocated to work together to support people who needed assistance from two staff, while other care workers would be allocated to support people who only needed assistance from one member of staff. One care worker would be allocated to do drinks and check mattresses and such roles. Roles were allocated on a day-by-day basis, so care workers might care for different people every time they were on duty. There was a key worker system but this did not relate to individualised care plan development, it related to ensuring people had the toiletries they needed and other such matters. The system used by the service meant people may not receive continuity of care from the same member(s) of staff who they got to know and who knew them, as is recommended in good practice guidelines for dementia care.

The provider had not ensured people's care met all of their needs and reflected their preferences. All the above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was however, meeting people's needs and reflecting their preferences in other areas. We met with a person who spent most of their time walking about the ground floor of the building. Staff told us this was what the person usually did. They also told us the person could occasionally show behaviours that may challenge. The person had a care plan about actions staff were to take if the person needed additional support with their behaviours which may challenge. We asked staff about how they supported the person on such occasions. What staff told us reflected what was in the person's care plan.

Another person had an arthritic-type condition to one of their hands. This meant they needed support with managing their personal care in relation to their hand. They had a clear care plan about actions staff were to take to appropriately support them with their hand. The care plan fully reflected what staff told us about

supporting the person with their hand.

People's relatives were able to visit freely when they wanted to. One person's relative told us, "They have never restricted the times that I visit or how long I stay and they always make me feel welcome. If I'm here when the drinks trolley comes round they always offer me a drink as well."

There was an activities worker in the lounge during the morning and in the afternoon. During the morning, the activities worker ran a range of group activities supporting people in the way each individual needed, and included those people who were who were significantly less able as well as people who were able to participate. This activities worker had a positive manner, praising people with their successes and encouraging people to join in. People responded well to this approach, clearly enjoying what was provided. During the afternoon, the activities worker spent some quiet time engaging with people in the sitting room with one to one activities.

The provider had a complaints procedure, which was made available to people and their supporters. One person's relative told us, "I've never had cause to complain at all, they've always been very willing to help and support us in anyway they can. I think if I had any problems all I would have to do is talk to the manager and it would be sorted." We looked at complaints records. We saw the registered manager investigated all complaints and concerns, including verbal concerns. They responded to people in a timely manner and in writing.

The service had provided care to people at the end of their lives in the past. They were not providing care to people with such needs at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

At the last inspection, this key question was judged to be good. At this inspection, we found the rating had deteriorated to inadequate.

The registered manager for this service also acted a senior manager for another service owned by the provider. This meant they spent parts of their time away from this service, supporting the other service. The registered manager was supported by a deputy manager. There was always also one registered nurse on duty, who was supported by senior carer workers, care workers and ancillary staff. The provider owned another service in the area. They also owned two other services, both of which were separate legal entities.

The provider's system for auditing the quality of the services provided was not robust in all areas. This was because they had not identified a range of areas and ensured action was taken. This included the provider's own infection control policy, which among other areas, emphasised the importance of ensuring the cleanliness of all trolleys. On the first day of the inspection, the medicine trolley wheels were visibly trailing dust as it was pushed along the corridor, on the second day of the inspection a cleaners' trolley had visible debris attached to its wheels and the chassis of the trolley was not clean. The provider's own policies also emphasised the importance of removing dust from all horizontal surfaces. On the first day of the inspection, deposits of dust were clearly visible on flat surfaces in the laundry. On the first day of the inspection, we also found a wide range of other areas relating to cleanliness and hygiene, such as a dirty bathroom floor, unclean bedrails, unclean wheelchairs, light pull cords which showed staining where a person would hold it to turn the light on and cloth chairs which were not clean on their hand rests. These had either been addressed or were in the process of being addressed by the second day of the inspection, however they had not been identified by the provider's own systems and relevant action taken before our inspection.

The provider had performed an audit of their own compliance with the MCA and DoLS in July 2018, however they had not identified the areas we identified during the inspection. Regular health and safety audits took place, however they had not identified that the exit tubing for the tumble dryer in the laundry was taped together; this tape was falling off and encrusted with dust. We have referred this, and some other matters to the Fire and Rescue service. The provider's own systems had not been robust enough to identify other areas. This included prevention of pressure damage risk, appropriate management of catheter drainage leg bags, management of certain aspects of medicines, choice for people at mealtimes and effective care planning.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken action in other areas. The provider had nearly completed a process of installing sprinklers throughout the home to ensure people's safety in the event of a fire. They performed regular checks on key areas such as the functioning of the call bell system and hoist slings. All relevant certificates such as Legionella and gas safety were in place. Notifications had been sent to CQC as required by law.

One of the directors showed us how accessible their computer system was. This meant they were able to

access it from anywhere, so they could, for example review progress of a complaint or safeguarding investigation at any time, in order to support people, their relatives and staff appropriately. The provider regularly sent out questionnaires to people and their relatives. All the questionnaires we reviewed were positive about the service provided.

People commented positively on the management of the service. One person's relative told us, "The manager is friendly and approachable, willing to help." Staff also made positive comments about the ethos of management and the home. One member of staff told us, "Of all the care homes I've worked in, this is one of the best." Another member of staff told us, "The managers are very good at listening to people, if you bring things up, they take action. Things are always dealt with." Another member of staff told us, "We've a great atmosphere here and work well as a team." Regular staff meetings were held, these were minuted so all staff could review what was discussed and any required actions.

The registered manager and staff told us they worked closely with supporters in the community, including GPs, community psychiatric staff and the local authority. They told us an advantage of being part of a small group was they could work together, for example if specific staff training was needed.

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
Treatment of disease, disorder or injury	The provider had not ensured that the care provided to people was appropriate, met their needs and reflected their preferences by designing care or treatment with a view to ensuring people's were met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider was not ensuring all people were treated with dignity and respect by all staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured care and treatment was provided in a safe way to people. This was because they were not always appropriately assessing risk to people and doing all that was possible to reduce risk, this included medicines management and infection risk as well as other areas.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider was not ensuring all people's nutritional needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes operated effectively to assess monitor, improve and mitigate risk to people and others who used the service.