Ashdown Care Limited

Ashdowne 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

This comprehensive inspection took place on 30 April 2018 and the 8 and 14 May 2018. This inspection was brought forward because we received concerns about the service. These related to staff levels, safeguarding concerns and staff not following the Mental Capacity Act 2005 (MCA).

Ashdowne Care Centre 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.

Ashdowne Care Centre is registered to provide accommodation with nursing or personal care, for up to 60 people. There were 45 people using the service on the first day of our inspection. The service is located in the town of Tiverton. It comprises of two detached, two storey buildings linked by a corridor. The home is divided into two units, one in each building, Ashdowne and Pinnexmoor. The Ashdowne unit is primarily used for people with physical disability and the Pinnexmoor unit is for people with dementia or a mental health need. Each of these units has its own staff team, communal spaces and secure outside garden for people to use as they choose.

At our last comprehensive inspection in April 2016 the service was rated good overall and in all domains except effective. We issued the provider with a requirement because they had not ensured people were supported by staff who had the appropriate training and supervision necessary to enable them to carry out the duties they are employed to perform. Following the inspection the provider sent us an action plan telling us the improvements they would make. We returned and undertook a focused inspection in May 2017 and checked to see whether the requirement had been met and found it had been addressed.

A new registered manager started working at the service in May 2017 and registered with CQC In February 2018. A registered manager is a person who has registered with CQC to manage the service. Like registered persons, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from risk because people did not always have access to a call bell when in communal areas. People were not protected because risks for each person were not always assessed. Care records contained risk assessments for falls, nutrition monitoring and skin integrity. However these were not always completed in a timely way when people arrived at the service.

There were adequate numbers of staff on duty on the Pinnexmoor unit although concerns were raised regarding the staff levels on the Ashdowne unit. The registered manager explained that there had been staff shortages but staff had undertaken additional duties and staff had come across from the Pinnexmoor unit and the provider's other service to fill gaps. However they said they had not always been able to cover short notice staff sickness. They had recruited new care staff who were undertaking their induction. This meant

that there were staff working on the Ashdowne unit who were learning about the service and developing their experience. They had also increased the staff level because they had two new admissions.

Staff were knowledgeable about recognising the signs of abuse and had a good understanding of how to keep people safe. The registered manager had been working with the local authority safeguarding team regarding safeguarding concerns. During the inspection a person raised a safeguarding concern with CQC. We discussed this with the registered manager and operations manager and they made an alert and took appropriate action.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. New staff had received an induction when they started working at the service. There was a system to ensure staff received training to ensure they had the right skills and knowledge to meet people's needs. The registered manager had a system to delegate supervisions and appraisals; however these had not been undertaken for all staff. Where concerns had been raised about two staff, no supervisions had been undertaken to discuss and look at the staff's performance and development needs.

Staff recorded accidents promptly in the accident book and the actions they had taken at the time. However the oversight monitoring of accidents and incidents to look for patterns and trends had lapsed. Therefore it was not possible to ensure that staff were responding appropriately and risks reduced, where possible.

The complaints log contained five complaints during 2018. However it was not evident if the registered manager had followed the provider's complaints policy. One complaint had not been dealt with in a timely manner and another had not been included in the complaints log.

Most aspects of medicines management were being safely managed. However, time specific medicines were not always being given at the required times and that cream charts were not always completed fully.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager and nurses demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. They understood where people lacked capacity, a mental capacity assessment needed to be completed with best interest decisions made in line with the MCA. They had submitted applications where required to the local authority Deprivation of Liberties Safeguarding team (DoLS) to deprive some people of their liberties.

Staff on the Pinnexmoor unit were friendly and kind to people and provided a good service. However at times on the Ashdowne unit staff were rushed and people's dignity was not always maintained. People were able to make daily choices about the care they received.

People were supported to have regular appointments with their GP, dentist, optician, chiropodist and other specialists.

There was a staff member designated on both units to undertake activities with people. There were records of activities people had undertaken on the Pinnexmoor unit. Where people could not or chose not to leave their rooms the staff member had spent time with people in their rooms to ensure they undertook meaningful activities and were not at risk of social isolation. However this was not recorded on the Ashdowne unit, only the activities which had taken place. Therefore the registered manager could not demonstrate that people on the Ashdowne unit were not being socially isolated. The staff member on the Ashdowne unit had needed to undertake care shifts to cover staff shortages. This meant there had been

limited activities on the Ashdowne unit. The operations manager said they would be increasing the allocated activity hours on Ashdowne to increase the oversight of the lounges and to undertake more activities. People had been asked in an activity review and said they were happy with the activities at the service.

People's needs were assessed with them before they were admitted to the home. Personalised care plans were developed and these were reviewed on a regular basis and when a change in their needs was identified. Staff had completed individual risk assessments for people to assess how to reduce risks as much as possible. However these were not always completed promptly when new people came to the service. The provider supported people who required end of life care.

People were supported to eat and drink sufficient amounts to maintain their health. People said they liked the food provided. A new summer menu was being implemented following a review with people to ask their views.

The registered manager held regular meetings with staff and actively sought their views. The registered manager said they were required by the provider to hold a residents meeting twice a year. They said nobody attended the last one so they spoke to individuals. They said they would arrange another meeting.

The premises and equipment were managed to keep people safe.

The provider is required by law to send CQC notifications about important events at the service. For example, deaths, serious injuries or safeguarding concerns. We received notifications as required from the provider.

We found three breaches of regulation. You can see what action we told the provider to take at the back of the full version of this 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 were not always protected from risk because people did not always have access to a call bell when in communal areas.

Staff had completed individual risk assessments for people to assess how to reduce risks as much as possible. However these were not always completed promptly when new people came to the service.

There were adequate staff levels. At times there were new staff working on the Ashdowne unit who had not developed the knowledge and skills to know people's needs.

People were protected by staff that were aware of the signs of abuse and would report concerns.

People were protected by safe recruitment processes.

Medicines were safely managed. Improvements were required on the application of prescribed creams and time specific medicines.

Effective infection control processes were in place.

People's safety was protected by effective fire and environmental monitoring and practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received supervisions and appraisals. The registered manager had scheduled staff appraisals and gave us assurances they would be completed.

Staff received appropriate training to meet people's needs. Staff had received an induction when they came to the service.

The registered manager and nurses understood their responsibilities in relation to the Mental Capacity Act (MCA)

(2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

People received a nutritious diet and enough to eat and drink to meet their individual needs.

Advice and guidance was regularly sought from relevant professionals to meet people's healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect on the Ashdowne unit.

Staff knew people well and how they liked to be supported.

Relatives were welcome to visit at any time and were involved in planning their family member's care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were regular opportunities for people and those that mattered to them, to raise issues, concerns and compliments. The registered manager had not always responded to complaints in line with the provider's policy.

Care plans contained information to help staff support people in a person centred way and care was delivered in a way that best suited the individual.

People experienced end of life care in an individualised and dignified way.

People's social needs on the Pinnexmoor unit had been met but had lapsed on the Ashdowne unit.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a new registered manager at the service. The

provider's operations manager undertook regular visits and completed quality assurance audits. They had identified there were concerns at the service and had been working at the service to support the registered manager.

Accidents and incidents were recorded in the accident book by staff and the actions taken at the time. The provider had a system to analyse these but these had lapsed over the past two months.

There were audits and surveys in place to assess the quality and safety of the service people received.

Feedback was sought from people using the service, their relatives, staff and health professionals and any issues identified were acted upon.

Staff meetings took place regularly where staff were encouraged to discuss any issues with the management team.

People's views and suggestions were taken into account to improve the service.

Ashdowne Care Centre

Detailed findings

Background to this inspection

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

This inspection was brought forward because we had received concerns about the service. The inspection was also prompted in part by notification of an incident following which a person using the service sustained a serious injury that indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

This comprehensive inspection took place on 30 April and 8 and 14 May 2018 and the first two days were unannounced. One adult social care inspector visited the service on the first and third day of inspection. On the second day of inspection the inspection team consisted of two adult social care inspectors, a specialist advisor and two experts 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 the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners for the service and the local Health watch to gain their views of the service provided. Health watch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time with people living at the service. We also carried out observations using the short observational framework for inspections (SOFI). SOFI is tool used to capture the experiences of people who use services who may not be able to express this for themselves.

We spoke with 20 people who used the service and four relatives. We spoke with 18 members of the staff team including the registered manager, the operations manager, unit leads, nurses, administrator, receptionist, activities co-ordinator, maintenance person, eight care staff, members of the laundry and

housekeeping team and the cook.

We reviewed six people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine administration records for 41 people as well as records relating to the management of the service. At the inspection we spoke to a visiting community nurse. We also contacted health and social care professionals for their views. We received a response from none of them.

Requires Improvement

Is the service safe?

Our findings

This inspection was brought forward because we received concerns about staff levels and individual safeguarding concerns. This inspection found staff levels on the Ashdowne unit had been low at times due to staff absence, sickness and weather conditions. However the provider had taken action regarding the staff levels. The management team were working with the local authority safeguarding team regarding two safeguarding concerns. They were being open and transparent and were working to keep people safe. Therefore these concerns were not substantiated.

People were not always protected from risk because people did not always have access to a call bell when in communal areas. On the first day of our visit the only call bell in the Ashdowne ground floor lounge was partially obscured by a bookcase. We discussed this with the operations manager who said they were having a new infrared call bell system installed which would allow people to have pendants. A call bell lead had been put into place on our second day to make it easier for people to reach.

A person who had been assessed at high risks of falling used this lounge throughout the day. They had been at the service for nine days and had had two falls. We heard a person calling for help from this lounge. There were no staff in the area, we found the person standing and looking very unsteady. We pressed the alarm to request assistance and fortunately the registered manager was in the area. The staff made us aware that they could not hear the call bell when supporting people in their rooms. They said, "You cannot hear the lounge call bells when you are in a room with the door shut. It's been very stressful here."

People were not protected because risks for each person were not always assessed. Care records contained risk assessments for falls, nutrition monitoring and skin integrity. However these were not always completed in a timely way when people arrived at the service. This meant these people could be at risk because measures might not be put into place to protect them. The registered manager said they would address this concern.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this with the registered manager and they put in place 15 minute checks for the person and ordered a chair alarm. At the end of the inspection the operations manager said they would be increasing the activity hours so there would be a staff member present in the lounges more of the time, which would take pressure off the care staff. The new infrared system would mean that the call bells would be heard when care staff are in people's bedrooms.

The operations manager had identified that care staff were undertaking people's weights but were not recognising on the nutritional assessment when a significant change had occurred. They had been working with the nurses and care staff regarding this. The nurses reviewed people's risk assessments each month. Where they identified concerns in relation to people's skin integrity, pressure relieving equipment had been put into place.

A check list had been completed for people using bed rails that included the risk of entrapment. Protective bumpers were used on the bedrails and the use of the bedrails were reviewed on a monthly basis. The dimensions of the mattress were in line with the bedrails used. Pressure mats used to alert staff that people assessed as requiring them were active within their rooms were checked three times a day to ensure they were working.

People and relatives on the Pinnexmoor unit and most on the Ashdowne unit said they felt safe. Comments included, "Nothing to worry about here, I feel ok about everything" and "No complaints about anything, I feel safe and sound here; they come and look at me at night." Two people on the Ashdowne unit said they did not feel safe. "One commented when asked, "No not really I get really worried." The registered manager and operations manager spoke with this person during our visit about their concerns.

During our visits there were sufficient numbers of staff on duty on the Pinnexmoor unit. However at times on the Ashdowne unit staff were rushed and busy completing tasks with a mix of experienced and new staff working. There was a nurse on duty on both units at all times. On the Pinnexmoor unit there were 20 people supported by five staff in the morning and four in the afternoon. On the Ashdowne unit there were 24 people with four care staff throughout the day, this was increased to five in the morning during the first week of our inspection because there were two admissions. The operations manager said they monitored staff levels. They completed individual dependency assessments for people to assess their level of needs. They said they started with a ratio of one care worker to four people on the Pinnexmoor unit and one care worker to five people on the Ashdowne unit.

The registered manager said there had been staffing difficulties on the Ashdowne unit. They explained that there had been staff shortages due to short notice genuine staff absences and sickness. They said staff had undertaken additional duties and staff had come across from the Pinnexmoor unit and the provider's other service to fill gaps. However they said they had not always been able to cover short notice staff sickness.

They had recruited three new care staff who were undertaking their induction and had other staff due to start once their employment checks were completed. This meant there were new staff working on the Ashdowne unit who were learning about the service and developing their experience. The registered manager said they had not needed to use agency staff but the providers would if required. However after the inspection the registered manager informed us that they had needed to fill gaps using a local agency.

Staff said that the staff levels on the Ashdowne unit had been "bad" but raised no concerns about the staff levels on the Pinnexmoor unit. Staff comments included, "Existing staff have had to work twice as hard", "We have only been short for an hour or so if someone goes off sick. The nurse phones around to find someone to come in" and "Some of the time staff don't bother to ring in sick so we have been doing extra hours to cover. As far as I know it's been dealt with. A lot more staff have been employed recently, a couple started last week and another new one this week." The registered manager was addressing staff sickness levels by meeting with staff to undertake a return to work interview to see what support they required.

People were protected by staff that were very knowledgeable about the signs of abuse and had a good understanding of how to keep people safe. They had received training in safeguarding of adults. They had a good understanding of how to report abuse both internally to management and externally to outside agencies if required. Staff were confident the management team would respond to any concerns raised. The registered manager had been working with the local authority safeguarding team regarding safeguarding concerns. During the inspection a person raised a safeguarding concern with CQC. We discussed this with the registered manager and operations manager and they made an alert and took appropriate action.

Medicines were safely managed apart from cream charts that were not always being completed. Also, time specific medicine were not always given at the required time. The operations manager said they would remind the nurses of the need to give time specific medicines at the correct time and monitor that staff completed the cream charts.

The nurses at the service administered people's medicines. We observed a nurse administering people's medicines, they were patient and ensured people had a drink to take their medicines. Records were completed correctly and after the person had taken the medicine. The morning medicine round took two and a half hours to complete. The nurse said this was due to the amount of medicines people required. The operations manager was looking at ways of reducing this time.

Medicines were stored securely, including those requiring refrigeration. Records were kept in relation to medicines received into the home and medicines disposed of. A pharmacy review in November 2017 by the pharmacy providing medicines at the home did not raise any significant concerns.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks, which included references from previous employers and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The premises were well managed to keep people safe. External contractors undertook regular servicing and testing of moving and handling equipment and fire equipment. Fire checks and drills were carried out. There were individual personal protection evacuation plans (PEEPs) which took account of people's mobility and communication needs. The registered manager reviewed these each week to ensure all new people had been included. This meant, in the event of a fire, staff and emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. Legionella checks were completed. Pressure mattress settings were checked on a daily basis when undertaking personal care. The mattress settings were determined by trained nurses in accordance with people's weight.

People were protected by appropriate control of infection processes being in place. Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The provider had an infection control policy in place that was in line with best practice guidance. The registered manager had completed an infection control audit in February 2018 and had taken appropriate action to address areas of concern. The housekeeping staff used a cleaning schedule to ensure all areas of the home were kept clean. They used different coloured mops for different areas to prevent cross infection. For example, red for soiled and toilets, yellow for use in lounges and corridors, blue for the kitchen and green for the laundry areas. The laundry room was tidy. There was a system in place to ensure soiled items were kept separate from clean laundered items. Staff confirmed there was always a good stock of detergent available.

Requires Improvement

Is the service effective?

Our findings

This inspection was brought forward because we received concerns about staff not following the Mental Capacity Act 2005. These concerns were not substantiated during this inspection.

Not all staff had received supervision and appraisal as is necessary to enable them to carry out the duties they were employed to do. The registered manager had put in place a supervision and appraisal schedule with the expectation that staff would receive three supervisions a year and an annual appraisal. The registered manager undertook the supervision of heads of departments and had allocated responsibilities to heads of departments for other staff. However since September 2017 these had not always been completed, mainly for staff on the Ashdowne unit. The registered manager was aware of this and said they were going to have a real drive to get these completed. Where concerns had been raised about two staff, no supervisions had been undertaken to discuss and look at the staff's performance and development needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where staff had received supervisions they felt supported and positive. One staff member said it had enabled them to have their say, make suggestions for change and was asked whether they were happy in their role.

New staff were supported to complete an induction programme before working on their own. Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. The provider had a comprehensive induction program booklet that staff completed. New care workers who had no care qualifications, undertook the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. The operations manager said that new staff were supernumerary for at least two or three shifts dependant on their experience. All new staff completed manual handling training before undertaking shifts and a fire safety induction. Both heads of units were manual handler trainers. One new care worker said, "My induction was helpful. I haven't had any problems."

There was a robust system to ensure all staff completed the provider's mandatory training. As well as the provider's mandatory training staff had undertaken other training to help them in their roles. These included, challenging behaviour, person centred care, diet and nutrition, risk assessments, diabetes, dementia, coping with aggression, record keeping, equality and diversity and death and dying.

Nurses are required to be registered with the Nursing Midwifery Council (NMC) in order to practice. The provider undertook NMC professional registration checks when the nurses started at the service and then regular checks to ensure they remained registered. Help and support had been given to registered nurses who need to undergo a process known as revalidation in order to maintain their professional registration.

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. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the home was meeting these requirements. The registered manager and nurses understood their responsibilities in relation to DoLS and had made applications to restrict some people's liberties in line with the MCA. Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity. Staff received training on the MCA and demonstrated an understanding of people's right to make their own decisions. We identified some staff were not clear about the MCA but established these were new staff and had MCA training scheduled.

People were supported to eat and drink sufficient amounts to maintain their health. People said they liked the food provided. Comments included, "Very good …food not too bad at all to be honest …; "The food is good not brilliant but good" and "I would recommend the dinner here, something different every day." A new summer menu was being implemented the week after our visit which had been produced after a catering review had been completed with people.

The cook had clear information about people's dietary needs. Where people had a specialist dietary requirement the staff ensured they had what was required. Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had assessed people as requiring a special diet these meals were provided in the required consistencies for people. A personal nutritional profile had been developed for each person detailing food and drink preferences and if especially adapted cutlery was required. One person had lost over three kilograms of weight and staff were weighing them on a two weekly basis and encouraging extra snacks throughout the day.

We observed mealtimes in both units. On both units the tables were laid with a table cloth, cutlery and napkins, condiments were brought to the table as people required. People were given a choice of fruit squash to drink with their meal. All staff involved in the dining experience wore aprons and gloves. The care staff plated meals up at the table side. During our visits staff were mostly seen supporting people with their meals in a calm, unrushed manner. For example, one care worker checked each time a person was ready for his next mouthful. However we observed a poor lunchtime experience whilst sitting on the Ashdowne unit on our second day. Staff did not ensure people were sat in a manner which was conducive to eating; they did not listen to people's requests and were rushing the process. For example, a person was slouched down in an armchair with a meal placed out of reach. The staff member saying, "if you need help I will come and help." A second person asked for a small meal and was given a large portion. We discussed this with the management team and they said the team on duty consisted of new care staff and they would discuss this with staff.

People had been asked the previous day for their preferred meal choice. We discussed with the management team that there were no menu's on display to remind people with memory problems what the meal options were.

People and relatives confirmed the staff contacted health professionals promptly when they required support. Comments included, "I don't need to see the doctor, but I am confident that if I did they would arrange it for me, no worries", "When I was poorly they got the doctor, they came and saw me and sent me to the hospital, when I got better I came back here" and "I have just seen them, I have a bad cold, the nurse called the doctor for me." Relatives confirmed that staff contacted them to make them aware of any health concerns. One relative said, "My (person) was very agitated and upset, they rang me in the evening to tell me that two care staff were having to stay with him, later they rang again stating that he was much more settled and was sleeping, they were wonderful and so reassuring."

The provider had an on-going redecoration programme in place to improve and maintain the environment. Redecoration of the Ashdowne unit's two lounges and dining area were being undertaken. The operations manager said there would be new flooring and furniture for these communal areas. Following the inspection the registered manager confirmed these rooms had been decorated and the new furniture had arrived. The Pinnexmoor unit had numerous memorabilia on display and displayed crafts which people had completed. There was a reality orientation board in the lounge with the time, day, date and weather detailed. The doors to people's rooms were numbered with no distinguishing features and the person's name in very small print.

Requires Improvement

Is the service caring?

Our findings

We spent time talking with people and observing the interactions between them and staff. Staff on the Pinnexmoor unit were kind, friendly and caring towards people and people were seen positively interacting with staff chatting, laughing and joking. Comments from people included, "The staff are nice and kind mostly, no real moans", "They are all nice and kind to me and everyone else, nothing is too much trouble" and "Everyone is kind and caring towards me." A relative said, "The staff are wonderful, I had heard bad things about this home, but they are not true, this place is really good, I cannot fault it."

Staff on the Ashdowne unit at times were rushed and task orientated and did not always have the time to interact with people. Staff said they were busy because they had some complex people to support. One care staff said, "I am frustrated not achieving anything. They don't respect how hard we work, I go home feeling I haven't spent time with the residents." The staff on the Ashdowne unit were seen to have developed good relationships with people and knew their needs well. One person said, "Sometimes they are really busy and you have to wait, but when they come to me they get everything just right."

Staff mostly treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. For example, they knocked on bedroom doors before entering and gained consent before providing care. One staff member said, "We promote privacy by closing the door and covering people up when they are having personal care. We assist them to the toilet and make sure the door is shut. We ask people what they would like to eat and we watch non-verbal behaviour and facial expressions." We discussed with the management team that staff on the Ashdowne unit did not always treat people respectfully. For example, staff did not always knock on doors before they entered, a staff member placed a food protector on a person and said, "You need your bib done up." At other times staff were joking between themselves in front of people, and not including the people.

Staff involved people in their care and supported them to make daily choices. For example, people chose where they would like to spend the day and the clothes they wore. Staff were seen when transferring people using a hoist explaining the process to the people and ensuring they were happy to proceed.

People's relatives and friends were able to visit without being unnecessarily restricted. A receptionist role had been introduced at the service. Their role was to meet and greet visitors and support them as required.

People's rooms were personalised with their personal possessions, photographs and their own furniture.

Requires Improvement

Is the service responsive?

Our findings

People's complaints were not managed according to the provider's policy. The service had a written complaints policy and procedure about how to raise a complaint. It included contact details of other organisations people could contact if they were dissatisfied with how their complaint was dealt with by the home. The complaints log showed there had been five complaints received in 2018. Three related to poor care with two of these raising concerns about staff attitude. It was not clear how these complaints had been responded to and investigated. There was very little information in the complaints folder to show that the registered manager had followed the provider's complaints policy. The registered manager said they had emails which they needed to print to add to the file. They also said they were still dealing with an outstanding complaint from February 2018.

A person raised a concern with CQC at the inspection regarding a staff member's attitude. They confirmed they had raised the concern with the registered manager the same morning. We discussed this with the registered manager who told us they had received another concern about the staff member. They had recorded in their manager's book that the person had complained that the staff member had been rude and did not care. They had recorded that they had returned to the person a few days later after the staff member had worked another shift and the person had said "They had a better night." The registered manager had not recorded this in the complaints log and they had not spoken to the staff member regarding the concern. This showed that the registered manager did not follow the provider's policy or took action to keep people safe.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have access to activities and were at risk of social isolation. There was a staff member designated on both units to undertake activities with people. There were records of activities people had undertaken on the Pinnexmoor unit. Where people could not or chose not to leave their rooms the staff member had spent time with people in their rooms to ensure they undertook meaningful activities and were not at risk of social isolation. However this was not recorded on the Ashdowne unit, only the activities which had taken place. Therefore the registered manager could not demonstrate that people on the Ashdowne unit were not being socially isolated

The staff member on the Ashdowne unit had needed to undertake care shifts to cover staff shortages. This had meant there had been limited activities on the Ashdowne unit. The registered manager said they would put in place a more concise activity recording system on the Ashdowne unit. The operations manager said they would be increasing the allocated activity hours on the Ashdowne unit to increase the oversight of the lounges and to undertake more activities. People had been asked in an activity review and said they were happy with the activities at the service. Following the inspection the registered manager confirmed that the activity provision had been increased on the Ashdowne unit and covered five days a week.

On the Pinnexmoor unit there was a clear activities plan in place, this was displayed on the wall of the

lounge. During our visits people were using the outside garden areas on both units. There were regular external entertainers booked who visited the service which people said they enjoyed. Those wanting to have spiritual support were able to receive communion at the service monthly.

People's care and support needs were well planned and information was updated when their needs changed. Before people came to the service the registered manager visited them and completed a comprehensive pre admission assessment. They discussed their requirements with them to assess if the home could meet their needs. Following a pre admission assessment, care plans had been written to guide staff how people would like to receive their care, treatment and support.

Care plans were person centred and gave staff guidance about how to support people. For example one person was noted to shuffle when trying to mobilise. Staff were asked to ensure the person had good fitting footwear on prior to attempts to mobilise. We observed staff supporting people to maintain their independence as far as possible. The care plans were reviewed on a monthly basis or more often if there were changes. This ensured the care plan was a working document that reflected people's level of need and care. People and relatives were involved in the care plan process and with the reviews as they were able and as they chose. One relative said, "My grandfather and I have discussed the care, he could not sign the document, so I did it for him as I have Power of Attorney" they went on to explain "We will have another look at this in a few weeks' time."

People's files contained a social profile that detailed travel experiences, special occasions, previous occupation, activities enjoyed and what TV programmes, radio and music the person enjoyed. Antecedence behaviour and consequence analysis charts were being used to understand the triggers of challenging behaviour and guide staff in how best to manage it.

Staff attended a handover meeting at the beginning of each shift. This meant staff were informed of people's changing needs.

The service were working to implement the Accessible Information Standard (AIS). They met people's individual information and communications needs in ways to achieve independence. The AIS is a framework put into place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can understand information they are given.

There were two people receiving 'end of life' care at the time of our visit. Their care plans reflected the changes in their needs and the support they required in order to guide staff. Staff had consulted with the people's family and GP to ensure they were informed. Medicines had been put place should the person require them for pain management. People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. Relatives had sent thank you cards to the team thanking them for the care the staff had given their loved one.

Requires Improvement

Is the service well-led?

Our findings

The service had a new registered manager who had been working at the service since May 2017 and registered with CQC in February 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was supported by a head of unit for Ashdowne and one for Pinnexmoor. The previous registered managers still worked at the service, with one being the head of unit for Pinnexmoor. The registered manager said they were getting to know the service, the staff and the provider's systems. They said staff had been disgruntled regarding staff absences and the cold weather. They recognised the reasons why but was aware some staff felt they were to blame. People and relatives knew who the registered manager and the heads of unit were and said they were happy they could speak with them. One person said, "(head of unit) is wonderful, she does everything just so."

Staff said the registered manager was approachable but two felt they did not always take any action when concerns were raised regarding staff levels. Other staff comments included, "Very supportive, you can go into the office at any time, she is a really good listener", The managers are responsive and listen to staff… The provider has given me good support and the manager is approachable. We have an online diary for staff who want time with the manager. I have no concerns here", "She is really a good role model for the staff to follow" and "The manager has a large task ahead."

The provider had quality assurance procedures in place to monitor the safe running of the service. The provider had an annual program of required audits, meetings and checks which the registered manager was required to undertake. A monthly manager's report was also required which recorded information regarding admissions, staffing, review of care records, recruitment, incidents and accidents and pressure damage. A recent manager's report had recorded an untoward incident regarding the recent bad winter weather where staff had not been able to attend work. Learning had taken place regarding this; the registered manager said they had a contingency plan in place regarding staffing if bad weather was experienced again

The provider's operations manager visited the service every six weeks and undertook checks, audits and spoke with people, relatives and staff. They had identified concerns at the service through their quality monitoring processes. They were working at the service alongside the registered manager to deal with these and implement processes to prevent further concerns. For example improved recording charts, more specific staff meetings, improved completion of prescribed cream charts, finishing processes which had been started and a clearer staff rota system. One staff member said "Things have improved since (operations manager) has been here." The provider had also visited the week before our visit. The management team were monitoring the role of the nurses at the service and developing a more coordinating role over their shifts.

Staff had recorded accidents promptly in the accident books and the actions they had taken at the time.

However the registered manager and nurses had not always completed the provider's falls grid and analysis tool. This meant they could not look at trends and patterns and identify if action was needed to prevent further accidents. The operations manager had identified this concern and was supporting the registered manager to fully reinstate the use of these tools.

People and those important to them had some opportunities to feedback their views about the home and quality of the service they received. The provider's operations manager had sent out surveys in May 2017 to people living at the home, visiting health and social care professionals and visitors. The responses had been mostly positive with all responses from relatives confirming their relative's needs were being met by the service.

The provider required that residents meetings were held twice a year and relatives meetings twice a year. The registered manager had had a meet and greet meeting when they arrived at the service in the spring 2017. They said they had arranged a residents meeting but nobody had attended therefore they had spoken to people individually. They said they would arrange another meeting. Newsletters were produced to keep people and relatives informed. A monthly newsletter for people and a bi monthly newsletter for relatives. These contained information about planned social events, activities that had taken place, decoration to the home, brain teasers, events in the local area and staff changes.

Staff were involved in developing the service. Full staff meetings were held twice a year as well as meetings with individual departments. For example, nurses, kitchen staff and housekeeping. The registered manager held a weekly 'communication' meeting with a representative from each team, including catering, maintenance, laundry, housekeeping and nurses.

The provider had displayed the rating of their previous inspection in the main entrance of the home.

The service was inspected by an environmental health officer in relation to food hygiene and safety. The service had been awarded the highest rating of five. This showed the provider had ensured good standards and record keeping in relation to food hygiene.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practical to mitigate risks to people. 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not ensured complaints received at the service had been investigated and necessary and proportionate action taken in response to any failings found. 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received supervision and appraisal as is necessary to enable them to carry out the duties they are employed to do. 18(2)(a)