Coate Water Care Company Limited

Ashbury Lodge Residential Home

Inspection report

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Date of inspection visit:
31 May 2017
01 June 2017
05 June 2017

Date of publication:
05 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashbury Lodge is a care home without nursing that can accommodate up to 44 people. The accommodation is arranged over two floors and the home is situated on the outskirts of Swindon. At the time of our visit, 41 people were using the service and one person was in hospital. The inspection took place on 31 May and 1 June 2017. This was an unannounced inspection. Feedback was given on the 5 June 2017 when the registered manager returned from leave so they had the opportunity to be part of this inspection. This inspection was brought forward in respect to concerns reported to CQC about the service. One further concern was received during the inspection. We did not find evidence of these concerns at the time of our inspection.

There was a registered manager in post when we inspected the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection in April 2016, the home received a rating of requires improvement and were in breach of four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made but we found that the service had one repeated breach of Regulation 17 Good governance and one new breach of Regulation 11 Need for consent was identified. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks, however we found that people did not have moving and handling risk assessments in place and information in their mobility care plans did not provide staff with clear guidance. One person was on a behaviour monitoring chart as there had been several incidents of aggression towards other people and staff. We saw that this person had no risk plan in place to manage these behaviours and there was no clear guidance on what staff were to do to support this person.

Staff had received training in how to recognise and report abuse and were clear about how to report any concerns they had. Staff were confident that the registered manager would respond appropriately. People we spoke with knew how to make a complaint if they were not satisfied with the service they received.

The service had not always obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences. Staff did not always demonstrate sufficient knowledge around the principles of supporting people who lacked capacity.

The service had remained in breach of the Regulation for ineffective recording in care plans. There was often inconsistent or conflicting information which made it hard to ascertain a person's most current needs.

There continued to be mixed responses from people, their relatives and staff about the activities provided

by the service. We observed activities including board games and crafts during our visit and people being asked to participate.

We found that one notification of abuse had not been raised to CQC or The Local Authority Adults Safeguarding team. We raised this with the senior management team who submitted the necessary notification and conducted an investigation into this. The outcome of this event was that the recording did not accurately reflect the events and the person concerned was found to not have been placed at risk when this incident occurred.

Improvements had been made to the décor of the home including redecorating the bathrooms and installing new flooring.

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.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks, however we found that people did not have moving and handling risk assessments in place and information in their mobility care plans did not provide staff with clear guidance.

Where a person had been identified with behaviour that could at times be aggressive, an appropriate risk assessment and care plan had not been put in place.

There were systems in place to ensure that people received their medicines safely.

Staff had a good understanding of how to identify safeguarding concerns and act on them to protect people.

Is the service effective?

Requires Improvement

The service was not always effective.

The service had not always obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences.

Staff did not always demonstrate sufficient knowledge around the principles of supporting people who lacked capacity.

Improvements had been made to the décor of the home including redecorating the bathrooms and installing new flooring.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed.

Is the service caring?

Good

The service was caring.

People and family members we spoke with gave us positive feedback about their care workers and told us they were caring.

Staff told us how they aimed to provide care in a way that promoted people's independence.

People and their relatives were given support when making decisions about their preferences for end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service had remained in breach of the Regulation for ineffective recording in care plans. There was often inconsistent or conflicting information which made it hard to ascertain a person's most current needs.

There continued to be mixed responses from people, their relatives and staff about the activities provided by the service. We observed social activities happening in the home during our visit and people being asked to participate.

Ten complaints and concerns had been reported to The Care Quality Commission about the home; however none of these had been raised with the management through their formal complaints process. There was clear guidance on how to make a complaint displayed around the home.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

We found that one notification of abuse had not been raised to CQC or The Local Authority Adults Safeguarding team.

Although quality monitoring was in place, issues around Mental Capacity, behaviour management and care plan recording had not been identified in order for action to be taken prior to our inspection.

People, their relatives and staff spoke positively about the registered manager and felt able to approach her with any concerns.

The home had made some improvements since our last inspection and senior management had supported managers to work closer together and share their knowledge, ideas and good practice.

Ashbury Lodge 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 inspection took place on 31 May and 1 June and was unannounced. Feedback was given on the 5 June 2017 when the registered manager returned from leave so they had the opportunity to be part of this inspection. This inspection was brought forward in respect to nine concerns reported to CQC about the service. One further concern was received during the inspection. We did not find evidence to substantiate these concerns at the time of this inspection.

The inspection team consisted of two inspectors and a pharmacist from CQC medicines team. The home was last inspected in April 2016 and received a rating of requires improvement with four breaches of the regulations identified. Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 10 people living at the home, eight relatives, 14 staff members, three health professionals, two supporting managers, two senior management and the registered manager.

We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for twelve people, medicine administration records (MAR), staff files, the provider's policies and a selection of the services other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day and spoke with people around the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2016 the service was found to be in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because communal bathrooms were in a state of disrepair and infection control had not been well managed. An action plan was provided by the home which stated they would address this situation without delay. At this inspection we saw the home had taken action to meet the requirements of this regulation. Prior to our inspection we received concerns about odours in the home. During our inspection we spent time reviewing the cleanliness of the home and did not find that these concerns were substantiated during this visit.

We saw that communal bathrooms and toilets had undergone a programme of redecoration to bring them up to standard. These were clean and any odours in the home were promptly attended to by members of the housekeeping team. We saw documented evidence to show equipment was being checked and attended to when necessary and cleaning schedules were in place to record that areas of the home were cleaned daily. Some relatives told us that the home was not always as clean as they would like commenting "It's kept clean but I have had to pull them up before about my relative's room. They are meant to do a deep clean once a month but they don't pull the bed out, it can be dirty, I have raised this", "Different cleaners, different strokes, the toilet areas are not always clean", "It's clean, my relative has complained. I make allowances" and "The bathrooms sometimes smell."

Risks to people's personal safety had been assessed and plans were in place to minimise these risks, for example where people were at risk of falling or skin breakdown. We found that people did not have moving and handling risk assessments in place, but information was recorded in their mobility care plans. We found the information was vague and did not provide staff with clear guidance. We saw in one person's care plan that they had poor posture and stooped too much, which meant they could not sit safely in a chair and so was cared for in bed. The care plan only stated "To provide safe moving and handling. Staff to take precautionary measures when using the full body hoist. Staff to practice proper manual handling." It did not give specific guidance regarding moving the person.

We saw one person's bedroom had a lot of equipment kept in it which made the space small and hard to access. Throughout the inspection we saw a wheelchair, crash mat and hoist was kept in the room. We pointed this out to the registered manager on the third day who said the person did not spend much time in their room but agreed it reduced the accessibility and could be moved.

We saw that one person had a crash mat beside their bed which had been put in place following an incident when they had fallen out of bed. However this person did not have a sensor mat on top of the crash mat so if they were to fall again staff would be alerted to come and assist. The registered manager told us that staff would check regularly but there were no records of these checks . The registered manager told us that they would obtain a sensor mat for this person.

Some people living in the home would at times display aggressive behaviours and would need support from staff to manage these in a safe way. We saw a protocol in the care office describing actions to take if a

person had a change in behaviour and became a risk to others. The protocol was about general actions and we looked in people's care plans for specific support methods personal to the individual, but this information was often missing.

One person was on a behaviour monitoring chart as there had been several incidents of aggression towards other people and staff. We saw that this person had no risk plan in place to manage these behaviours. On one incident it recorded only one action on the behaviour monitoring chart which stated 'Staff walked away'. It did not offer detail on if the person and other people were offered support and their safety monitored. There was no clear guidance on what staff were to do to support this person. One member of staff confirmed there was no care plan or risk assessments in place for this person and then stated this was because it was a one off incident. However we saw that this was not a one off incident as there had been several similar incidents. In February 2017 during a staff meeting this person's behaviour was discussed as staff had concerns. One health professional told us "Their knowledge base of challenging behaviour and dementia is average to good, there's a lack of behaviour recording in most homes." The registered manager told us on the last day of inspection a behaviour care plan and a new updated risk assessment had now been put in place which was person al to the individual so staff would have guidance on how to safely support this person.

For people that chose to smoke, staff kept their cigarettes in the medicines room and their family would bring more in when needed. We saw that there was no safe procedure in place to manage these cigarettes to ensure that people received all of their cigarettes. The cigarettes packs were labelled and kept in a carrier bag but staff did not sign in the amount of packets a family member brought in so there was no way of safely monitoring them. The cigarettes were accessible by anyone who had access to the medicines room. We raised this with the registered manager to address. After the inspection we were informed that the service had taken some action in response to this and asked family members who purchased the cigarettes if they were happy with the procedures in place, to which they confirmed that they were.

The home had maintenance staff who completed weekly and monthly checks including building, water and fire safety. Equipment such as wheelchairs and beds were checked regularly and staff knew to report any concerns and visually check all equipment before they used it. Personal evacuation plans were in place for people which highlighted the support they would need to safely leave exit the building in an emergency. We saw that one person would walk around at night and a sensor mat would be placed by the front door in the evenings to alert staff to their presence so they could check and offer support if needed.

During our inspection there was an incident where one person who was unsafe to leave the building without a staff member present managed to exit the front door. Staff could not prevent the person leaving as it would have escalated the situation, so instead spent time walking with the person down the road to keep them safe until they could encourage them to return to the home. This person returned with staff a short time later and the situation was managed safely.

Relatives that we spoke with felt their loved ones were kept safe in the home commenting, "I feel that [X] is safe", "I have no concerns about my relative being safe" and "My relative is safe, it's the best, she loves all the staff." One person told us "I had a fall; I think that's why I came in here. I feel safe here." Staff had a good understanding of how to keep people safe and their responsibilities for reporting any concerns. Staff told us "I have had training in safeguarding, I would report concerns to a senior or the manager at the first point of call, or I would go higher", "I have had training, I would report anything, its people's lives at risk", "It's about making sure everyone is being treated as they should and that people are safe. I would report to the manager or report externally", "Make sure people are well, it's what you should be doing and safe from abuse. Report to the manager and if nothing is done I would go higher. We have been given a booklet of who

to contact" and "It's about protecting people, it wouldn't matter if it was staff or my family, if it's not right I would report it. You can't have anything going on with vulnerable people, I'm passionate about safeguarding." The registered manager told us "Lessons are learnt and every safeguarding we have is shared with staff."

The home employed sufficient levels of staff to meet support people and meet their needs. Staff were visible during the inspection and each floor had senior members of staff on duty to oversee each shift. People and relatives gave mixed comments in relation to the staffing levels in the home commenting "I think they work very hard, they could perhaps do with more staff", "I can always find someone", "At times I think they are a bit short", "There are enough staff, mum is looked after, I'm here regularly", "At weekends they could do with another member of staff" and "There is enough staff available for people, and consistency of staff here." Some staff that we spoke with felt the staffing levels were adequate and afforded them time to spend with people whilst other staff felt at times they needed extra staffing saying "There is enough staff and time to chat with people", "Generally there's enough, we can have a one to one with people", "We have enough staff", "Sometimes there could be more staff, generally it's ok and not rushed, you can't rush people", "New staff have come in. The night staff have quite a turnover of staff", "In general there should be an extra member of staff to float between floors", "There is enough staff, we can spend time with people and "Is there ever enough, in an ideal world people would have one to one."

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

Prior to our inspection we received concerns about medicine management in the home. For this reason we included a pharmacist as part of our inspection team to conduct a comprehensive inspection into the safe management of people's medicines. We did not find that these concerns were substantiated during this visit.

During our inspection, we looked at the systems in place for managing medicines. We spoke to two staff members involved in the governance and administration of medicines, observed medicine administration for six people and examined 42 medicines administration records (MARs). People's medicines were managed safely. There was a system in place for ordering, receiving and disposal of medicines and records were completed to document medicines that had been received into the service. There was a separate refrigerator on each floor for medicines needing cold storage; records were available to show that the temperature range was being recorded daily. There was a procedure in place for what to do if the refrigerator was outside of the safe range. The pharmacy provided printed medicines administration record (MAR) charts for staff to complete when they had given people their medicines. We found that where handwritten charts were in use these were usually checked signed and dated by two staff members. Where additional instructions for the application of creams and external preparations had been written onto pre-printed MAR charts a number of these had not been signed. This was raised with management to address.

The application of creams were recorded on topical MAR charts which were completed separately. We checked 44 of these records; all had instructions to guide staff when and where to apply the preparation. Body maps were in use for the application of medicine patches, which helped to make sure they were applied and used correctly. The opening dates of creams and eye drops were recorded to ensure that these were discarded within the required time range, to reduce the risks of infection. For medicines prescribed 'when required' there was sufficient information with the MAR charts about how or when these medicines were to be given. This helped to make sure people received them in the correct way. Staff administering

medicines had received training and had annual competency assessments. We observed medicines being given to people. This task was completed in a thoughtful manner with consideration to their needs. People were asked if they needed any medicines that had been prescribed for them on a 'when required' basis, for example pain relief.

There was no-one who looked after all of their own medicines at the time of this inspection, but there were policies in place to allow this if people wished, and after it had been assessed as safe for them to do so. Two people were receiving their medicines covertly (without their knowledge) and a policy was in place to allow this which followed accepted guidance and the appropriate documentation to show advice had been sought on how best to administer these medicines was recorded.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS authorisations as required. Applications had been submitted to the Local Authority Supervisory body for which some were still awaiting a response and some applications had been authorised. We found people were not always receiving care and treatment in the least restrictive way. We observed that people did not have access to the garden, which was locked. During our inspection we observed people walking to the door and walking away once they realised it was locked. People relied on staff to take them out. We raised this with the registered manager who told us people's safety was at risk when out in the garden, but would reassess to ensure they were providing care and support in the least restrictive way.

We saw mental capacity assessments were used to decide if a person had capacity to make key decisions about their daily living needs and chosen lifestyle. However there was no evidence on the mental capacity assessments of who was consulted, what the discussions had been and how the decision was made in the person's best interest. We also found some mental capacity assessments to be contradictory, for example it would state the person had capacity to make day to day decisions, but questions regarding the person's understanding and retaining information to make an informed decision, suggested the person lacked capacity.

The Mental Capacity assessment incorporated various day to day decisions, such as eating, drinking, washing and dressing. For more complex decisions such as consent to covert medicines, there was no reference on the mental capacity assessments of any discussions and how the best interest decision was made. The registered manager told us there was separate documentation to evidence the discussion and best interest decision. We saw for one person in the mental capacity assessment regarding likeliness to refuse or forget to take medicines; it did not mention the person was taking their medicines covertly. It only stated staff intervention was required to ensure medicines were ordered and administered. The assessment did not record information on what was tried to support the person in retaining the information or how the decision was reached.

Some people had given others lasting power of attorney (LPA) in relation to either their finances or their care and welfare. This gave them the power to take decisions on behalf of the person if they lacked Mental Capacity. The service had obtained details of LPAs where people had them; however this was not

consistently recorded in people's care records. The registered manager kept a log of who had a LPA, however had not always seen a copy of the LPA, which meant relatives or representatives could be making best interest decisions on behalf of people without having the legal powers to do so. One person had a lock on their door that family had wanted in place after a series of incidents. The person did not have capacity to keep the key to their room so staff had one key and the family retained the other. There was no LPA in place for family to make this decision on behalf of the person and no capacity assessment or best interests meeting had taken place to ensure this action was not restricting the person from accessing their room. The registered manager informed us after these concerns were raised that a care plan around this had been put in place and a best interests meeting would be held.

Some of the staff's knowledge around Mental Capacity was not always clear despite having received training. Comments from some staff included "It's about protecting people if they are making an unwise decision", "If they can't decide what they want. We might think it's good for them" and "Some people are resistant to care, if it's in their best interests to have a wash, get a DoLS." Other staff told us "If someone doesn't have capacity to make their own decisions, it has to be in their best interests and have someone appointed to help them. We present clothes to people to choose, we show a sample of meal choices to people to choose", "We make sure people have choices, certain people can't make decisions, we support them" and "Be able to make choices where they can, if deemed necessary do it in their best interests. Show people the choices, always promote choices, if I was to be in a home I would appreciate the choice." One health professional commented "The knowledge of staff is average for the home, their knowledge base has improved."

We saw that hourly night checks were being completed for everyone in the home regardless of if people slept fine and did not need to be checked on an hourly basis. There was no consent sought or obtained for people or evidence that this had been discussed with people first to ensure they were happy to receive this level of supervision during the night. The approach taken had been a blanket approach to include everyone rather than a person centred approach.

For people that smoked, staff kept their cigarettes in the medicine room and would accompany people outside when they required a cigarette. This had not been included in the capacity assessments to show that people had been consulted or were unable to take responsibility for the management of their own cigarettes. Senior and supporting management informed us they needed to look at the structure of the assessment on a wider level because whilst they considered it to be good for including detail about smaller decisions where the person may be able to make a choice; it was not as good at recording information around more complicated decisions.

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

At our last inspection in April 2016 the service was found to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not all up to date on the necessary training required to perform their role. An action plan was provided by the home which stated they would address this situation without delay. At this inspection we saw the home had taken action to meet the requirements of this regulation.

Staff spoke positively about their induction into the home commenting "We get at least four shadow shifts around the home, we work on both floors to be familiar with each floor", "I was introduced to the home and had shadow shifts, I felt very supported and had training", "Induction was quite in-depth, felt by the time I had finished I was ready to crack on. Training is done regularly, I have done Mental capacity, DoLS and first

aid" and "I got shown around, met residents, shown my duties everyone was helpful."

Staff had received training in managing behaviours that may challenge dementia and other training necessary to their role. Where some gaps were noted or coming up for refreshing further training had been booked for staff throughout the year. One staff said "We do annual refreshers it's on-going." One staff felt more awareness was needed for people with dementia commenting "More dementia awareness for staff coming into the home would be good, as to why people say and do things, to understand them is needed."

People were supported by staff who had supervisions (one to one meeting) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had commenting "We have Supervisions with the seniors regularly and can bring up any issues and they ask if we feel we need any more training", "I have had a supervision and was asked if I had any issues" and "We have these regularly." We observed a few gaps on the staff supervision record where staff had not received their supervision in the provider timeframes and raised this with the registered manager to address.

At our last inspection in April 2016 the service was found to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always supported with their meals in a dignified manner. An action plan was provided by the home which stated this would be reviewed and action taken to address it. At this inspection, although we saw some examples of ineffective practice, the home had made enough improvements to meet the requirements of this regulation.

We observed for people upstairs who had chosen to eat in the lounge or in their bedroom their meal was taken to them without a protective cover on to keep it warm or to prevent spoilage. One person was supported by a staff member to eat their lunch and their pudding was brought out at the same time as their main meal and left uncovered on the tray beside them during this time.

There were delays in serving lunch to people in the upstairs lounge, one person had their meal served at 12.10pm, whilst another person sitting next to them did not receive their meal until 12.25pm and had to wait and watch other people eating. Some people had moved onto their pudding just as other's were receiving their main meal. One person was given their meal at 12.10pm and fell asleep with it in front of them. Staff gently woke this person at 12.25pm to encourage them to eat but by this time their meal would have been cold and had been left uncovered during this time. One staff took another person's meal away and told them they would save it until later.

All other aspects of mealtimes were positive and staff were on hand to support people where needed. One staff member noticed that a person had chosen to only eat particular parts of their meal and responded by offering to fetch the person more of what they had enjoyed. Another person told staff they did not fancy their meal at that time and staff respected their wishes and were seen to continue and check if the person was ready at different intervals. The menus were clearly displayed for people and the chef showed us new pictorial menus that had been put together which gave people information on the ingredients and calories that were in the meal.

We saw that people were supported to dining tables at mealtimes and asked where they would prefer to sit. The tables were laid nicely with condiments and people were offered a choice of drinks. People spoke positively about the food saying "It is lovely food", "The meals are pretty good", "The food is excellent, we get a choice. We have snacks and coffee" and "The food is remarkable, the chef does a good job on limited means." One relative told us "The food is ten out of ten, if they don't like something they will make something else." Another relative said "My relative likes the food and can get a cooked breakfast." The chef explained that for people on a soft diet they took time to ensure the food was still presented in an appetizing

way and we saw this during our inspection. A morning and afternoon trolley went round offering people snacks and hot or cold drinks of their choice. The chef would speak to each resident on a monthly basis to see if there was anything in particular they wanted on the menu. One staff member told us "The kitchen is running like clockwork now."

Since our last inspection the home had put in place 'Protected mealtimes' to ensure that people were given staff's full time and concentration during mealtimes. Relatives and visitors to the home were informed of this and posters were up explaining that staff should not be disturbed at these times so the time could be spent supporting people.

People had access to health and social care professionals and the home would make referrals where appropriate. For one person in the home that had a grade two pressure ulcer we saw staff had responded quickly in referring to the community nursing team and requesting pressure relief equipment. They had also contacted the GP for a prescription for a barrier cream to prevent further skin breakdown. One health professional told us "They really do care for their clients, now we visit regularly they are better able to assess when a person needs to be seen." Relatives told us they were kept informed about events affecting their loved ones commenting "The home let me know if mum is not well or talk to me when I come in", "They will ring if not well and tell us" and "They let me know if she has a fall, I can't fault them."

The home had made improvements to the décor of the home which included redecoration of all communal bathrooms and toilets, new flooring which was easier for people to mobilise on and reminiscence boards up on the walls for people to enjoy. The registered manager said it was important to them that any decorations were in keeping with the homely feel of the building. One relative told us "The décor is nice; it was the first thing we noticed about the home." We could see that people's rooms were decorated to their tastes and they were able to bring their own furnishings and ornaments to personalise their space. One staff member told us "It's homely here. We have had improvements made, new flooring, redecorated and blinds."

Good

Is the service caring?

Our findings

Prior to our inspection we received concerns about the standards of care in the home and that people did not look well cared for. During our inspection we spent time observing people's experience and talking with people about the care they received. We did not find that these concerns were substantiated during this visit.

People told us they were happy with the care they received from staff commenting "It's very comfortable here, staff are nice", "I'm quite happy, people are nice. We are well looked after. The staff are lovely, they ask how we are, they can't do more than they are doing", "I am happy living here, staff are alright, they are lovely", "Most of the staff are good" and "It's not bad living here." Health professionals spoke positively of the care staff gave commenting "Staff appear to know their residents", "Staff knowledge of people is very good and the consistency of staff is good" and "The staff are all very caring towards people. Staff have knowledge of people its well organised."

We saw that most people preferred to spend their time in the main lounge areas. Staff told us that one person particularly liked to sit in a certain place with their chair turned facing away from the sun and staff ensured this was adhered too. Another staff member said "It's a friendly homely place; staff do treat residents as their family." We saw that pictures of people and artwork that they had made were displayed around the home for everyone to enjoy and recognise.

Relatives told us that the staff were caring commenting "My relative is well cared for, they treat her perfectly", "I come in quite a lot, I like it, from what I have seen of the staff they are good. Staff are caring", "Staff are friendly" and "It wasn't our first choice but we are pleased with the care she is getting here. All staff know about my relative if I ask they have been open with us."

Most interactions we observed between staff and people were respectful and supportive. We did observe one person repeatedly getting up out of their chair only to be told by three different members of staff to sit back down. On one occasion one staff member gently eased the person back into their chair and on another the person was told to sit down and they could have a "Nice cup of tea in a minute." At no point did staff enquire if there was somewhere else they could help assist the person to, or if that person just generally wanted to take a short walk and stretch their legs. This was not representative of other interactions we observed. One staff member was observed encouraging a person to change position in their chair to improve their posture. The staff gave the person plenty of encouragement, and spent time supporting the person without rushing them. The staff further asked if this person would like a cushion to make them more comfortable.

One person told us "Staff are respectful, they would do anything, we get looked after pretty well." A staff member said "We discretely encourage people to go to the bathrooms and change. Communication is key, they have to know what I'm doing and why." A health professional commented "Staff are always respectful during my visits and involve the client and their family where applicable." One relative told us "They put the music on that my mum enjoys and that is written in her care plan and that's good."

Staff told us that people were encouraged to be as independent as possible commenting "I let people do as much as they can", "I always see how much a person can do for themselves, offer a choice of drinks and not assume anything, they always have the choice" and "If someone is being assisted with care, we give choices of clothes and washing. If you do it for them they will let you so we give them independence." One person told us "I have lived here a few years, I am quite independent but I ask for help." A health professional told us "Staff enable people; one person has thrived since being here." Another health professional said "They offer choices where applicable and take time to allow residents to process information if they are able."

People and their relatives were given support when making decisions about their preferences for end of life care. We saw end of life wishes were detailed with people's preferences, such as having family photos around, playing soft music or a request for a priest to be contacted for a final blessing.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2016 the service was found to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans were seen to lack detail and guidance for staff in supporting people's needs and often contained conflicting information which made it hard to establish a person's most current needs. An action plan was provided by the home which stated they would address this without delay. At this inspection we found that the service had not taken enough action to meet this Regulation and remained in breach.

The home used an electronic system to document people's care plans. We saw that care plans were not always person centred. For example in people's personal hygiene care plans, it did not always evidence information about how the person preferred to have their personal care. Instead it stated "Requires assistance of one carer in maintaining personal hygiene. X [person] can do a lot for themselves with support". This did not offer staff information on what parts of care people could do or any personal preferences on how they liked their support in order to promote person centred care. After our inspection the management team sent further evidence to demonstrate this person's care plan had been updated to now include more information on their personal preferences.'

Some information in people's care plans was often contradictory which meant it was hard to ascertain the current level of needs for that individual. For example we saw that for one person it stated in their skin integrity care plan that there were no areas of concern and they maintained a healthy intact skin. This was dated the 30 May 2017, however on the 28 May 2017 in the person's daily record, it stated they had an open sore and had requested a district nurse.

People who were at risk of their skin breaking down and unable to position themselves were monitored on a repositioning chart. We found for one person that the information was contradictory. For example the person's skin integrity care plan stated they were not mobile and was therefore put on a reposition/turn chart. A recording on the chart stated "Stood up and walked a little" which was inconsistent to the person's care plan. We asked staff about this person's mobility and received inconsistent information which meant some staff did not have effective knowledge about this person's needs. We raised this with a supporting manager who had to take two members of staff aside and spend time attempting to establish this person's level of mobility. These staff were asked to immediately update the care plan with the correct information and that the care plans should reflect the support staff are giving, even if that meant updating a care plan on a regular basis. The supporting manager told us staff should have recorded more detail on the care plan as the person's mobility depended on their emotional well-being. Some days this person could move with encouragement and other days they could not.

Some people had behaviours that could be challenging to others. We saw there was some guidance in people's care plans on how to support the person. However this was often vague, for example where a person could become aggressive and ask to go home, it would state "Staff to reassure", but did not guide staff on what to say or do. We checked daily records and saw that when a person refused personal care, it did not evidence what staff did and if they returned later to support the person. Where there had been

incidents of a person becoming aggressive, the daily records did not always evidence what action staff had taken to support that person. This meant there was not a consistent approach for staff to follow that was person centred to the individual in supporting them. Following our inspection further evidence was provided that demonstrated an inclusion of this detail was now recorded in this person's care plan.

We saw that a bath and shower chart was still in place allocating people's names to different days of the week. In the corner the chart stated this was only a guide. The registered manager informed us that it was in place to ensure that everyone was offered the opportunity to have either of these but that they were not restricted to a certain day.

We saw that accident and incident forms did not always record the actions that had been taken to support people. The registered manager explained that this information was recorded by staff in the daily records but not on the accident forms. This meant you had to look back through the daily records to establish the outcome of each incident. The supporting manager agreed that they needed to link up the records to provide a clearer picture.

There was a high number of people who had been identified as being at risk of weight loss or dehydration and were been monitored on food and fluid charts, including ten people on the first floor. We also saw associated risk assessments were completed when people were losing weight. For example one person no longer understood the need to eat. Staff recognised that the person preferred to eat finger foods and were encouraging the person to eat. The person had also been assessed by the dietician. People that were at risk of losing weight had also been put on a fortified diet. However when we spoke with kitchen staff about how they knew which people were to receive a fortified diet and who was to receive a normal diet they told us that everyone had a fortified diet. This meant the service was not taking a person centred approach and people who did not need to be on a fortified diet had not been consulted and given their consent to this. We raised this with management who have informed us the kitchen staff now have a list of who is on a fortified diet and it has been made clear that only those people are to receive a fortified diet.

We saw that fluid charts were being totalled up to ensure people were receiving their recommended amount daily and where they were below this was highlighted so action could be taken. We saw that some people were consistently drinking under the recommended amount and the action on the recording sheet would state the same action 'Push fluids tomorrow', however this had been repeated for 15 days for one person and five days for another person. One person whose intake should have been 1600mls was recorded as having 305, 600, 730 and on one day only 40mls and some sips. Another person had also been consistently drinking under the recommended amount but the care plan recorded they had drank well. The registered manager explained the recording should have stated they had drunk well in comparison to what they normally did and should have been made clearer. The registered manager showed us that she was aware of people's fluid intakes and appropriate action had been taken when needed.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they found out about people's interests, family and life history by chatting with them and their relatives. One staff told us "Find out about people by communicating with the person directly, you can find out an awful lot and we share interests with them." People had life history posters displayed in their room which enabled staff to have conversations with people about their past and the things that mattered to them. We saw that staff also recorded people's repositioning checks on a whiteboard to have a visual reminder and would change the time it was next due after supporting someone.

People's needs were reviewed regularly and as required. We saw that for annual reviews a relative or representative was involved and signed that they were happy with the care plan on the person's behalf. Relatives told us they had the opportunity to be part of reviews commenting "I am involved in meetings about care", we come in and are involved in the care plan", "We can have a sit down and chat about his care" and "I'm not involved in reviews, I leave it to them, I give feedback." One staff told us "We review likes and dislikes for people, the chef asks seniors once a week if there are any changes with people and this is documented.

The service had started using an assessment called Pool activity level, which enabled carers or activity coordinators to recognise the ability of each person with a cognitive impairment to engage in an activity. The tool used also provided information about which activities would be suitable, depending on each person's assessment. It also supported activities coordinators in planning how they would be supporting a person with their activities. We saw people could take part in activities such a skittles, dominoes, cards, colouring or arts and crafts. People could also get involved in baking, for example pizza or jam tarts. We saw one activity being enjoyed by a few people in the garden. The activity coordinators also spend one to one time with people looking at family photos and playing a shopping list game. Some people had an interest in laying the table at mealtimes and we were told one person would help with folding the towels and serviettes.

Comments from people in regard to the activities provided were not very positive, and people did not feel there had been much improvement in this area since our last inspection. Comments included "They don't give you anything to do, you just sit and then go to bed", "We just sit here and watch TV, I don't go out in the garden much, I don't want to, there's nothing really to do", "Activities are a problem, we do have people who come in to sing. I don't think we have enough to do, I don't get to go out much, I used to go out for coffee before I came here", "There's nothing to do, I wait in hope someone like you turns up so I can have a chat", "I was doing crafts this morning, I have been out in the garden this morning, it's lovely out there now" and "I feel rotten every day, there's nothing to do."

Because of these comments we conducted a Short Observational Framework for Inspection (SOFI2) in the upstairs lounge during the afternoon on the second day of inspection. This allows us to observe care and interactions to help us understand the experience of people who could not always talk with us. We did this primarily to understand the levels of engagement people received
from staff. The SOFI2 showed us that some of the people we observed were engaged by staff or given something to do such as a book to look at or a game to play, however some people did not show any active engagement and spent time passively watching other people. The Pool activity level which has recently been introduced in the home will enable staff to identify more effectively an individual's engagement needs and tailor activities around this.

Relatives commented on the activities provided saying "Downstairs people are engaged", "Mum is ok if they give her some activity to do, she used to do things downstairs but upstairs they don't do a lot", "There are enough, a lot don't want to mix", "They have trips out, I went along on one of those, they have nice entertainment come in", "I have discussed activities and requested for my relative to go out on the trips. Some activities are too simple for my relative. It's not the staffs fault as they have so many needs to meet" and "My relative does a bit of colouring, they get her to join in." One health professional said "On my visits I have witnessed staff engaging and encouraging residents to participate if they wish. They have a client group that presents with many challenges." We saw that access to activities such as crafts and board games was restricted. Staff explained that they needed to lock things away and monitor people using them as some pieces were quite small and not everyone had the awareness to use things safely. We saw there had been a previous incident where it was thought one person had swallowed part of a game but the piece was

found a short while after.

Staff told us there was a lot of people in the home who preferred not to get involved in activities commenting "Some people upstairs don't like to engage but it's offered to them, some people like colouring or scrabble, we leave things in front of them and they will pick it up and play with it", "People have enough to do, some don't want to do anything and others do", "A lot don't do a lot but they have the option, we went to garden centre last week", "A lot of the time they don't want to do anything, others enjoy things. People go out and pick blackberry's and been to the beach last year", "On a day to day basis there is enough activities, but there could be more", "In the summer evenings from 5pm there is no one in for activities" and "If someone constantly refuses, you can't make them do something, but I don't give up I will put something in front of them and create a conversation." One staff told us "I go through people's photo albums with them and one person recognised their mum from a picture and wouldn't let me turn the page, that person knew the picture meant something. If they see pictures of what they have done it's great, the little moments we have makes my job worthwhile."

Although nine concerns and a further one during the inspection had been reported to CQC these had not been raised with the management of the home through their formal complaints process. At this inspection people and their relatives told us they would be happy to raise any concerns they had and we saw an easy read complaints process was displayed to guide people in making their concerns known. Comments included "I do get little complaints but they get sorted out", "I have nothing to grumble about regarding this place", "I would be happy to raise any complaints", "Very good, no complaints" and "No complaints about Ashbury." One person did say "I haven't made a complaint, but I should have a long time ago." We checked that this person knew how to make their complaint if they should decide too and they informed us they were aware and were still considering this.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection we had received information that the service was not displaying the rating from the last inspection on their website correctly. We raised this with the registered manager and action was taken in a timely manner to address this. When we visited the home we saw that the ratings were clearly displayed for people, their relatives and staff to view.

We found that one notification of abuse had not been raised to CQC or The Local Authority Adults Safeguarding team. We raised this with the senior management team who submitted the necessary notification and conducted an investigation into this. The outcome of this event was that the recording did not accurately reflect the events and the person concerned was found to not have been placed at risk when this incident occurred.

A registered manager was in place at the service and was managing two homes at the time of our inspection splitting her time between the two. The registered manager plans to continue overseeing the two homes until a new management team is in place and will then be moving to manage one of the provider's other home permanently. The registered manager was on leave when this inspection took place so we extended the inspection to provide feedback on her return so the registered manager had the opportunity to be part of this inspection.

Although quality monitoring was in place issues around Mental Capacity, behaviour management and care plan recording had not been identified in order for action to be taken prior to our inspection.

The registered manager kept an evidence based folder of things they completed in the home to monitor the service. An audit diary specified what should be audited each month and then extra audits were done on a random basis. Medicine audits were completed on a weekly and monthly basis and any issues were fed back to staff and actions taken documented. A monthly manger report documented information including any falls, pressure care and people who had lost weight. Concerns were discussed with staff and together they would consider what need to be done and what could be put in place as a preventative measure. The registered manager shared the quality monitoring information with people, their relatives and staff and displayed it outside of the office. This helped to make everyone aware and take a collective approach and also showed people what their information was used for in helping to identify concerns.

Weekly meetings were held in the home between the heads of department to share important information across the home and discuss any concerns. We attended a 'Flash meeting' during this inspection and saw it was an opportunity for seniors to update the management with that day's events and any important information relating to people in the home.

We received nine concerns prior to this inspection and a further one during the inspection. The concerns included cleanliness, care of people, medicine management and a lack of leadership in the home. In response to this concerning information the decision was made to bring the inspection forward to ensure that people were not at risk of unsafe and ineffective care. The registered manager told us "The concerns

raised are a challenge; it's not a reflection of the care, we would act on that immediately. I have shared the concerns with staff and they are shocked and don't feel we deserve it."

Staff spoke positively of the management during this inspection commenting "I think [X] is an excellent manager always on the ball", "The manager is working between two homes but is frequently available", "I can reach her in the office or over the phone when I need her and have an instant replay", "The manager is a very approachable person", "I have respect for the manager, she's very supportive and understanding and patient. I see her often, she's still taking an active role here", "I have never worked with a manager like this. Very good and open" and "I feel supported, I wouldn't be frightened to say anything."

People and relatives told us they were sad the registered manager was leaving the home and said "I see the manager about. If you have something wrong you can go to them and they listen. Its home from home", "The manager was marvellous. She is a lovely person, she's really good. Always there if you want to talk to anyone", "I don't see the manager to chat to, but she's very approachable", "I saw the manager yesterday but she's moving on", "We do get to see her, she's available and "Management have changed, only seen the new manager a few times." One health professional said "A well run home, I would put my mum in there definitely I would. I personally feel confident that we have a good care home there." Another health professional commented "The manager is about on the floor, always approachable, professional, she knows her residents. The registered manager spoke passionately about the service and told us "I care, I want to make sure that residents and staff are ok."

Staff were able to attend regular team meetings and felt supported to discuss things with their peers or manager. Staff told us "We work well together as a group", "Everyone is friendly here, we support each other, it's a stable team, and the residents make it, they are lovely", "Very good staff team. Well trained, each staff member works as a team" and "We work as a team." Staff had opportunities to progress into senior roles and take on more responsibility as well as being supported to complete higher qualifications. The registered manager told us "It's a good staff team; we have never had concerns raised until now. I can't fault them they all work together they all want to achieve the best. We are keen to rectify anything, we have a good team behind us, I can't praise the staff enough."

People were encouraged to participate in the service through regular resident meetings and feedback surveys. We saw a recent resident meeting had discussed having a remembrance place created in the garden where people who had sadly passed away could be remembered and their names put on pebbles. The registered manager told us that relatives were encouraged to be part of the service and one relative had completed a mealtime observation in the home and then provided feedback on this. Feedback surveys that had been completed did not show that people had concerns over the management of the home and the registered manager told us "No one has raised anything about management concerns. I wrote to the families about the arrangements with the management leaving the home."

One of the senior managers explained that prior to the last inspection a lot of work has taken place in supporting managers and enabling them to work more closely together. Another senior manager said "Managers are working a lot more closely together and share that knowledge. If things come in from CQC or the Local Authority we share amongst all homes to be more of a learning organisation." The registered manager referenced the improvements that had taken place in the home commenting "Everything in place is now embedded in the home."

The registered manger praised her support from senior management commenting "The senior management knowledge is brilliant, they put new systems in place, they check us, they are not strangers they update us and we get to go into other homes and learn more." The registered manager further told us the service

received good feedback from external professionals and worked hard to implement things that were recommended to them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had not obtained the appropriate consent before taking decisions on behalf of people to ensure care was given in line with their preferences. Staff did not always demonstrate sufficient knowledge around the principles of supporting people who lacked capacity. Regulation 11 (1).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Care plans were inconsistent and contained conflicting information. Regulation 17 (2) (c).

The enforcement action we took:

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