Three Ashes Care Home Limited

Three Ashes Residential Care Home

Inspection report

Ledbury Road
Newent
Gloucestershire
GL18 1DE

Tel: 01531820226

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 13 and 16 April 2018.

Three Ashes Residential Care Home is a 'care home' for up to 11 older people, some of whom were living with a physical or sensory disability. 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. Three Ashes is registered for older people living with dementia, physical disability and/or sensory impairment. At the time of this inspection 9 people were living there.

Accommodation at Three Ashes is provided over two floors with bedrooms located on the ground and first floors. The ground floor was wheelchair accessible. A stair lift was fitted to assist people with limited mobility to access the first floor. Most bedrooms had en-suite facilities with a shower and a communal bathroom was located on the first floor. Two lounge areas, one in a large conservatory overlooking the extensive gardens, were located on the ground floor and a dining area was situated, open plan, between the two lounges.

Three Ashes has changed ownership twice since our last inspection in November 2015 but the legal entity remained the same. At our last inspection in 2015 the service was rated Good. The home has been under the current ownership since August 2017. Staff working at Three Ashes at the time of the sale transferred across to the new owner, remaining in post at the home.

There had been no registered manager in post at Three Ashes since February 2018. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being managed by the provider's representative until a new registered manager was appointed.

During this inspection we identified two breaches of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. The service has been rated 'Requires Improvement' overall.

People were not always supported by staff who had received the training and support they needed to carry out their duties effectively. The systems and processes in place to monitor the safety and quality of the services provided to people were not always effective in identifying and addressing shortfalls. Complete records of the care and treatment provided to people had not always been kept. We recommend that the service review good practice guidance for managing medicines in care homes and take action to update their practice accordingly.

Risks to people were managed with the support and guidance of health professionals to ensure people

remained safe. There were enough suitable staff to meet people's needs. Staff worked openly with other agencies to safeguard people from harm. The building and equipment were appropriately maintained and people were protected from risks associated with cross infection.

People benefitted from a stable and caring staff team who knew them well. They were supported to access appropriate health care. Staff took a personalised approach to meeting people's needs and outcomes for people were good. People's preferences were taken into account by staff when providing care and people were offered choices in their day to day lives. People's privacy was respected and they were treated with dignity and kindness. People were supported to maintain relationships with others who were important to them. People received good end of life care.

People's views about the service they received were sought and these were used to improve the service. People were able to raise complaints and these were responded to promptly. The culture at the home was open and transparent. Staff and managers worked together to provide a friendly service where people told us they felt at home.

This is the first time the service has been rated Requires Improvement. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines as prescribed.

People were safeguarded from the risk of being supported by unsuitable staff because robust recruitment checks were completed and staff knew how to report safeguarding concerns.

People were protected against health and well-being related risks and there were enough staff to meet their support needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the training and knowledge to meet their needs effectively.

Improvement was needed to ensure the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were met consistently.

People were supported to make decisions about their day to day care.

People's health and nutritional needs were met and they had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and sensitive to their needs.

People were treated with respect, kindness and compassion. People and their close relatives were listened to and were involved in decisions about their care.

Staff understood how to communicate with people.

People's dignity and privacy was maintained and their independence in daily activities was promoted.

Is the service responsive?

Good

The service was responsive.

People received personalised care and were routinely consulted about the support they received.

Staff knew people well and worked flexibly to meet their needs. People were enabled to maintain relationships with those who mattered to them.

People were able to raise complaints and these were responded to.

People's end of life wishes were explored with them.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems in place to monitor and make improvements to the service were not sufficiently robust to identify and address all required improvements.

Complete records of the care and treatment provided to people had not always been kept.

The provider and management team worked openly with others, seeking their feedback, to improve the service.

People benefitted from an inclusive service where they were valued as individuals.

Three Ashes Residential Care 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 13 and 16 April 2018. The inspection was unannounced and was carried out by one inspector.

Before the inspection, we reviewed information we held about the service including notifications. A notification is a report about important events which the service is required to send us by law. We reviewed information the previous registered manager had sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with commissioners about the service.

Throughout the inspection we observed the support being provided to people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three people who use the service and two relatives. We spoke with a representative of the provider, the team leader and four other members of the care staff team, the chef, maintenance person, a health professional and a visiting hairdresser. We checked six people's care records which included pre-admission assessments, care plans, risk assessments and documents relating to assessment of mental capacity and Deprivation of Liberty Safeguards (DoLS).

We sought the views of a further seven health and social care professionals and received feedback from five of those we approached. We checked medicines records for three people and observed two staff members administering medicines. We reviewed the processes in place for managing medicines, including the use of

'as required' medicines and medicines with additional storage and recording requirements. We looked at recruitment records for four staff, staff training records, complaints, accident and incident records, maintenance records and reviewed provider policies and quality assurance systems.

Good

Is the service safe?

Our findings

People's medicines were managed safely. Medicines were ordered, stored and disposed of in line with current guidance and legislation. Regular checks meant appropriate stock levels were maintained and use of 'as required' medicines, occasionally used in managing people's anxiety, was monitored by managers. No concerns about medicines safety at the home were raised in the feedback we received from staff and external professionals. A pharmacist said, "If they [staff] have any concerns or queries they will contact myself or the team." People and their relatives were happy with how medicines were managed at the home. Their comments included, "[Person's] pills are all sorted out. I don't have to worry about [person] running out."

However, we found one person had an 'as required' medicine available for them, without a protocol in place to guide staff in its use. A senior staff member, we spoke with, did not know when this medicine would be needed, or how to give it. This shortfall had no impact on the person, as the medicine had not been needed in the months they had been living at Three Ashes. Some protocols for 'as required' medicines lacked sufficient detail and the reason for giving these medicines and their effectiveness were not routinely recorded. Despite the lack of detail in recording, further checks demonstrated that staff were giving these medicines appropriately.

We recommend that the service review good practice guidance for managing medicines in care homes and take action to update their practice accordingly.

Risks to people were understood and reviewed regularly, in response to people's changing needs.
Staff knew people very well and told us how risks to different people living at Three Ashes were managed to keep them safe. For example, one person living with dementia was "always looking for their parents" and could become anxious or agitated, as they couldn't find them. Helping the person to remember that their parents had passed away had recently become inappropriate; The person could no longer recall this happening and 'news' of their loss was "upsetting". Instead, staff used distraction and diversion techniques, including playing music, which the person enjoyed.

We observed the same person starting to fixate on having to, "go back to the school tomorrow". A staff member said lightly and confidently, "Don't worry, we can sort that out tomorrow"; The person visibly relaxed, smiled at the staff member and replied, "You're really good you are." The person was then able to move on, asking, "Is that my cup of tea?", as they re-engaged with the things around them. Effective use of distraction and diversion techniques minimised risks to the person and others and reduced the need for 'as required' medicines to manage their mood or behaviour.

Staff worked closely with health professionals to manage risks to people. For example, one person was unable to move themself to relieve pressure on their skin and was at high risk of developing pressure sores. The community nurse provided and set up a pressure relieving mattress and special sliding sheets were used to change the person's position in bed. These sheets remained under the person, at all times, so they could be moved easily, with minimal discomfort. However, use of the sheets created a risk the person could

slip out of bed, should they move involuntarily. To reduce this risk, bed rails were needed. A bed rails risk assessment had been completed, to ensure this combination of equipment was used safely and appropriately. The correct setting for the mattress was specified by the nurse and recorded in the person's relevant care plan. Staff informed the nurse of any weight changes and the nurse adjusted the mattress pressure setting accordingly. Despite being at high risk, this person's skin remained healthy and intact. Health care professionals told us the care people received at Three Ashes was "good".

The safety of equipment and the home environment was monitored and maintained. Regular checks protected people against risks associated with fire, legionella and equipment failure. Staff completed records of incidents and accidents, including any unexplained bruising and falls. A monthly summary was produced and an analysis of this information enabled trends to be identified and responded to. When a medicines error had occurred, the staff member involved was asked to reflect on what had gone wrong and what could be done to avoid a similar incident in future.

People were protected from the risk of abuse as staff understood their role in protecting people and followed the processes in place to safeguard them. Managers responded appropriately to any concerns or incidents, including involving external agencies. Staff told us they were confident managers would act on their concerns but they would contact company directors to raise concerns should they need to. We observed people were relaxed and at ease with staff. Comments from people and their relatives included, "I feel at home here" and "We felt comfortable with it [the home] from very early on."

People were protected against the employment of unsuitable staff because robust recruitment procedures were followed. All required checks were completed before new staff were employed. All staff completed an induction, which involved required training and working alongside experienced staff to familiarise them with each person's support needs. A staff member told us they had been allocated to care for the people whose needs were easier to meet to begin with.

Staff were relaxed and unhurried in their approach to people. Staff said they had time to meet people's needs. Comments included, "You can take your time and have a good chat [with the person]. There's time for the little bits." and "You can care for the residents better because you have more time". Care staff were supported by a full-time chef and domestic staff, who were responsible for cleaning the home. Laundry was done at night, which staff told us worked well.

The home was clean and free of malodours. Staff had completed training in infection control and food hygiene and personal protective equipment was available throughout the home. Staff followed the infection control measures in place. For example, wearing protective aprons in the kitchen and when assisting people to eat. Infection control audits had been completed as required by the provider and colour coded cleaning equipment was used to minimise the risk of cross infection. Three Ashes had been awarded a food hygiene rating of five (very good) in September 2017. One person commented, "I'm happy with the cleanliness."

Requires Improvement

Is the service effective?

Our findings

Improvement was needed to staff training and individual support (supervision) to ensure staff had the necessary skills and knowledge to carry out their duties effectively. This included appropriate training to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were always met and ensuring care records met expected standards.

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.

Some people living with dementia did not have the mental capacity to make decisions about their care arrangements. MCA assessments had not always been completed appropriately, as staff carrying out these assessments did not always understand how to meet the requirements. For example, MCA assessments had been completed for two people in July 2017, but in each case, the decision they related to was not specified. Steps taken by the assessor to establish whether the person lacked capacity and reasons for their conclusions were not recorded. In April 2018, the provider's audit identified that 'best interests' decisions, made further to MCA assessments, could not be evidenced. However, a training need was not identified. No further capacity assessments had been completed for either of these people, both of whom were living with dementia.

People who lack capacity to consent to their care can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care and nursing homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and had applied for the necessary authorisation when depriving a person of their liberty.

Applications to deprive people of their liberty had not always been submitted appropriately. Two DoLS applications had been authorised (without conditions). However, a further two applications had been submitted inappropriately and declined, as both people had capacity to consent to the arrangements in place. The staff member responsible for submitting DoLS applications told us they were unsure whether one other person required a DoLS authorisation. Advice had not been sought to clarify whether an authorisation might be needed and no further applications had been submitted for this person. The provider's representative said they would not expect staff to carry out MCA assessments, or submit DoLS applications, without first completing appropriate training. However, these learning needs had not been addressed through individual staff support meetings (supervision), or been brought to their attention, prior to the inspection.

Arrangements were in progress for staff to receive individual supervision from the provider's representative the week after our inspection. However, staff supervision records demonstrated staff had not received

regular supervision. For example, five of the eleven staff employed at Three Ashes, had not received supervision (or an appraisal) in the five months prior to our inspection. Staff told us they had not always felt well supported by managers, including through staff supervision meetings. Their comments included, "It [supervision] needs to be more meaningful." Two staff said they had not always felt able to express themselves in supervision meetings, as they were not confident the discussion would be treated in confidence. No staff had completed formal training in supporting people to manage their anxiety and associated behaviours. Four of the eleven staff, employed at Three Ashes, had not received training in dementia awareness and DoLS and no dates were booked for them to complete this training. Staff might therefore not have the skills and knowledge needed to support people effectively.

Training and supervision had not always been effective in ensuring staff had the skills and competency to support people effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the shortfalls identified above, we found the care and support provided to people was appropriate and there was no evidence these shortfalls had any impact on people. For example, our conversations with the two people for whom DoLS applications had been submitted inappropriately, assured us they accepted the restrictions in place at the home. This included the locked front door and agreeing to be accompanied by staff when they went out.

We observed staff checking with people before giving care; which included giving the person an explanation they could understand. Staff told us that if people declined care, they would return later and offer their assistance again. People's families were involved in decision-making when this was appropriate. For example, one person had an enduring power of attorney in place which authorised their relative to make decisions about the care and treatment they received. Staff told us this was respected and a copy of the relevant documentation was available.

Assessments of people's needs were reviewed regularly and in response to any changes. The provider's audit in April 2018 identified that care plans did not always accurately reflect people's needs or contain the information staff needed, for example, on actions to take to minimise risks to people. Training in care planning was included in the provider's action plan.

People were supported to maintain a healthy weight and had regular access to a suitable exercise programme, provided by a visiting specialist service. The Malnutrition Universal Screening Tool (MUST) was used to assess people's risk of becoming malnourished. Staff were assisted to manage this and other dietary related risks by the GP, whose advice was communicated to the chef. For example, the GP had recently advised staff on requirements for a low potassium diet for one person and foods this person should avoid were listed in the kitchen. We found some improvement was needed to ensure the chef had a comprehensive understanding of catering to the nutritional needs of people in residential care. For example, how to increase the calorific value (fortification) of food to support people at risk of weight loss. The chef told us they had no formal training in food fortification or meeting the dietary needs of people with diabetes.

The chef maintained a list of people's needs and preferences, including required food consistency and their likes and dislikes. People's weight was monitored monthly to ensure the measures in place were effective. People's food and fluid intake were monitored when this was indicated, for example, in response to weight loss. For example, one person at high risk of malnutrition had been receiving dietary supplements and was assisted to eat by staff. Since admission to Three Ashes, their weight had increased to a normal healthy weight and their food supplements and dietary monitoring had been stopped, staff continued to assist them, observed they were eating well and checked their weight remained stable.

Meals were prepared using fresh and frozen ingredients. Home baked cakes were served at tea time. Everyone we spoke with was complementary about the quality of the food and said there was plenty. There were enough staff available to assist people to eat at their own pace. Staff knew which people had difficulty with swallowing and how their food and drinks should be provided to reduce risks to them. Staff sat down while assisting people and chatted discreetly and respectfully with them, checking they had what they wanted.

The GP visited Three Ashes every two weeks to review people's changing health needs and saw anyone who was unwell more urgently. Health care professionals, including the dentist, optician and chiropodist, visited the home to enable people to receive preventative health care. A visiting health professional said, "It's very easy to visit and provide the service." They told us staff were always welcoming and available to provide any support or information they needed. This resulted in positive outcomes for people. For example, a person received new glasses during the inspection and commented happily, "I can see the TV much better!"

One person's relatives told us about the improvement to their relative's health and well-being since moving to Three Ashes. The GP had recommended the home to the family, when their previous arrangements were not working. On arrival the person had swollen, blistered legs and had been neglecting their needs. Their relatives said, "We are very happy, [person's] legs have gone back to normal. They [staff] make sure [person] keeps them up." They told us their relative was eating well and "looks the best we have seen [person] in a long time." Two other people had been admitted to the home for "end of life care"; Both showed no indications of reaching end of life, one eight months, the other three to four years after moving into the home.

Staff worked well together and described themselves as, "a good team". A handover sheet was completed for staff to refer to; to ensure planned appointments, events and people's changing needs were communicated effectively. Staff worked closely with health professionals who told us, "If they [staff] are ever concerned about a resident they always speak to us."

Technology was used to reduce risks to people, for example, a sensor matt was in place to alert staff when a person at risk of falls got out of bed. A call bell system allowed people to call for assistance during the night and if people decided to stay in bed during the daytime.

People and visitors described the home as having a "homely" feel, which they liked and felt comfortable with. Improvements to identified garden paths were planned to ensure people with limited mobility, including wheelchair users, could access more of the gardens. This was due to be completed before the summer, when a barbeque and garden party were planned. Further consideration was being given to adapting the communal bathroom and potentially installing a lift to the first floor to increase accessibility to people.

Good

Is the service caring?

Our findings

Feedback about staff was positive and included the following comments from people and their relatives, "They're alright. You can have a bit of a laugh and a joke. They are kind." and "We liked the staff straight away. They are just great." Comments from visiting professionals included, "The residents, whenever I have visited, seem well cared for and the atmosphere is happy and positive" and, "The residents always appeared happy and well cared for. The staff were always polite and showed empathy to the residents."

These observations complemented our own. We observed friendly banter between staff and people living at Three Ashes. For example, one person had their new glasses delivered during our inspection. A staff member said to the person, "You look like Clarke Kent now, you know Superman?" The person replied, "Don't you talk some rubbish!" which was followed with laughter from both of them. Another staff member said about a person living with dementia, "You have to laugh as it's sad; In the year I've been here, I can see a decline in [name] in particular. You wouldn't want to be in their head, it [effects of dementia] can be a frightening place."

Staff were prepared to go the extra mile on occasion to ensure people's needs were met. For example, a staff member told us it had taken them 10 months to get a special chair for one person. They said, "I fought for it, so [name] could get out of bed". The chair allowed the person, who was unable to sit safely in a standard armchair, to spend time in communal areas with others on the days they were feeling brighter and less sleepy. Staff were also supportive of each other and worked together as a "team". One said, "All the girls [staff] are very very supportive. It doesn't matter how many times you ask a question."

People's support plans guided staff in how to communicate effectively with them. For example, noting when they wore glasses or a hearing aid and if they needed shorter, simpler questions or more time to respond. For example, one person's care plan described how the person, who could no longer use speech, used body language to communicate. Staff were guided to observe the person's "eyes and facial expression and speak slowly and clearly." A staff member told us one person had "tunnel vision". They said, "You can stand next to [person] and [person] couldn't see you. You have to be in a certain place." A diary was used, at the request of one person's family, to help remind them of things that had already happened or were planned. A relative said, "When we have had queries they [staff] are all very receptive." Staff responded to people's cues and made sure the people were receptive to the support they provided. For example, one person said they were cold and a staff member said, ""You a bit cold [name]? Shall we get you dressed now?"

Resident meetings were held regularly, to give people information about changes to the service and provide an opportunity for them to ask questions, suggest activities or changes to the menu.

People's privacy and dignity were maintained. Personal care was given in private behind closed doors. Comments included, "There's plenty of privacy. Staff will knock on the door [to their room] before coming in". People's records were stored securely. People's dignity was maintained, for example, by helping them to care for their appearance. A relative said, "[Person's] always in clean clothes. They [staff] make sure it all matches." People were able to spend time privately in their room if they wished to be alone, or to have

private time with their friends or family. Visitors were welcomed warmly at any time.

A staff member told us how they worked with one person to maintain their independence while recognising the person needed more support and a different approach on days when they were less well. They told us this person, "responds to gentleness" and on days they didn't want to get out of bed, staff encouraged them to walk "to get their legs going" and "keep popping up [to person's room] to make sure [person's] hydrated and comfortable". When indicated, plate guards and adapted cutlery was used to assist people to maintain their independence while eating.

Good

Is the service responsive?

Our findings

People's records contained some information about their life history, things that interested them and people that were important to them. Details to support staff to provide care in a person centred way were not always included in care plans. This had been identified in the provider's audit in April 2018 and training in care planning was included in the provider's action plan.

People's support plans were in the process of being updated and transferred to a new recording system. Despite the lack of detail and absence of some relevant care plans, we saw that care and support was provided in a person centred way. For example, staff were aware that one person was self-conscious while eating and preferred to sit away from others during meals. While this was not detailed in their care plan, staff took the person's meals to their preferred seat without need for question or remark. A person living with dementia had fallen not long after moving into the home. Staff learned their former bedroom had been arranged differently, which may have confused them and contributed to the fall. In response staff moved the furniture so it was set out in the way the person was familiar with. They had not fallen since.

A social care professional told us about a person they "placed" at Three Ashes, who they were anxious may not settle. They said, "[Person] is still there a number of years later and has been more settled and content than I would ever have thought possible. This does reflect well on the way that staff have related to [person]… When I visit I am always impressed with the way that staff interact with [person] – they do treat [person] as an individual with [their] own history/personality – and not just as another resident." A health professional said, "The care provided is very good quality and personal. The staff know the residents well." Staff and professionals referred to Three Ashes as having a 'family atmosphere', where the small size of the home and stable staff team were important factors in providing a personalised service. One person said, "I know most of the girls [staff] here now."

The chef consulted with people when designing the menu to ensure their preferences were met. This included cooked breakfasts, prepared to order as requested. If people didn't feel like eating either of the choices on the menu, the chef was happy to prepare an alternative; They told us, "I'll find time, if that's what they want". One person we spoke with said, "You've only got to ask for it and he'll [chef] do it for you."

People were occupied in different ways, watching TV, reading the newspaper or the home's newsletter which had puzzles and 'this day in history' facts about Three Ashes included. Day trips had been booked, for example, to Bristol Aquarium and the nearby Birds of Prey Centre. People spoke enthusiastically about the planned days out, comments included, "That's jolly good that is" and "We're all going out for a meal." People were supported, on occasion, to go into Gloucester to shop and into the nearby town centre.

These trips were planned and staffed by care staff; there were no dedicated staff hours for provision of activities. On the days we visited, staff were unable to provide a formal activity in the home, as they were occupied in meeting personal care needs. Staff told us they found it difficult to engage people when they ran activities and external activity providers were much more successful at this. We saw two staff members were due to undertake specialist training in activity provision. One person's relatives told us, "We felt initially there

needed to be more to do but [staff member] is getting it going. It seems to be happening." They were impressed when their relative, who they described a shy person, told them they were "going on a trip." One person said, I can read my paper and go upstairs and do my jigsaw puzzle." They were looking forward to the trips out and warmer weather when they hoped to get out into the garden.

Technology was used to ensure people received timely support. When people were able to use them, call bells were left within reach so they could seek help. Mattress sensors were used when people were unable to use a call bell, but may be at risk of falls.

No complaints had been logged by the home since our last inspection, in the same time eight compliments had been received from various sources. This included an external training provider, who remarked upon the good relationships and communication staff had with people. Information about how to make a complaint was available in the home and people told us they could speak to staff if they were unhappy with the service. Relatives we spoke with had email addresses for the company directors and were satisfied with the response they had received from them and said things were, "Sorted really quickly."

People's wishes and preferences for the end of their lives had been discussed with them and the people who were close to them. Where people had expressed their wishes, basic information including their religious or spiritual beliefs had been recorded. Staff were proud of how well they looked after people who were reaching the end of their life, particularly as people admitted for end of life care often did much better than had been anticipated. We spoke with one person who had been admitted for 'end of life care' eight months earlier. They said, "I really didn't want to come here but it's been totally good." They told us they went out into town with staff, which suited them, "as long as they can keep up with me."

Staff worked closely with the GP and community nurses to ensure people had a dignified and comfortable death. This included clear identification of people for whom a 'do not attempt cardiopulmonary resuscitation' decision had been made and support in provision of specialist medicines to control unwanted symptoms.

Feedback to the home about end of life care from relatives included, "Staff were extremely caring and helpful in what was quite a stressful situation for all involved. Communication has been caring and sensitive and no pressure was put on us." A health professional told us a "patient" of theirs was given "outstanding care in the last days of their life" from the staff at Three Ashes.

Requires Improvement

Is the service well-led?

Our findings

Three Ashes Residential Care Home changed ownership in August 2017, but the legal entity providing the service remained unchanged. The registered manager and staff team at Three Ashes continued to be employed at the home, but oversight and working methods were changed in line with the new owner's sister services. A new operations manager came into post in October 2017. They were responsible for overseeing the provider's services and became the provider's representative to the CQC.

The first provider level quality audit of the service was undertaken on behalf of the new owners on 3 April 2018, two weeks before our inspection. Some shortfalls had been identified and an action plan was in place. However, this audit had not been effective in identifying all the shortfalls we found. This included staff learning needs, around MCA assessment, DoLS applications and behaviour management, some shortfalls in record keeping and submission of notifications to CQC. Improvements were needed to ensure the provider's audits would be sufficiently comprehensive to identify all potential regulatory and practice concerns.

Complete and meaningful records were not always maintained in the service about people's care. For example, care plans were not in place to support staff in managing behaviours that may challenge. This included, what situations the individual may find difficult, how to identify when people's mood or behaviour may be escalating and what actions staff should take. Some people were prescribed 'as required' medicines as a last resort in managing their mood. Records did not clearly describe when staff should give these medicines. Staff had not always recorded why 'as required' medicines had been given, or noted their effectiveness. This meant there was limited information available to evaluate the effectiveness of the care and treatment provided.

When specialist advice had been given, this was not always evident in care records. For example, two people had previously been assessed by Speech and Language Therapists (SLT), who had advised how their needs should be met to avoid risk of choking. It was not evident from these people's records where the information in related care plans had come from. As a result, when one person began to deviate from the soft diet recommended for them, the significance of this was missed, as the person appeared to be managing. Copies of the advice provided by SLT's could not be found in either person's record, so was unavailable for staff to refer to when planning or evaluating care. New SLT referrals were made for both people immediately after our inspection to ensure the support provided by staff was appropriate to their needs.

People's care plans were being rewritten at the time of the inspection, as records were moved onto the provider's record management system. There was a risk that as new care plans were being written, the advice provided by specialists such as the SLT could be 'lost' and important information omitted. Although the provider's audit had identified some shortfalls in care planning, including management of risks, the action plan did not reflect the extent of the concerns found. The only action listed was for care plans to be 'more person centred'.

A service certificate for electrical wiring safety at the home could not be located and no record was held to say when this had last been checked. The provider's representative told us this would be carried out as soon

as possible. No concerns had been raised about electrical wiring at the home.

The provider's audit identified that 'best interests' decisions, made further to MCA assessments were not in place. However, shortfalls in MCA assessments, lack of clarity around DoLS applications and the reasons for these shortfalls was not identified. This meant the learning needs of staff responsible for completing MCA assessments and submitting DoLS applications, had not been identified or included in the action plan.

The provider's audit did not include notifications to CQC and failed to identify that serious injuries to people and outcomes of DoLS applications had not been notified to as required. These notifications were submitted during the inspection.

The above demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was in post at Three Ashes Residential home until February 2018, when they de-registered. 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.

In February 2018, the provider's representative notified us they would be taking responsibility for the registered manager's duties; An acting deputy manager was to be appointed to support them in doing this, until a new registered manager was in post. At the time of the inspection, recruitment to the registered manager position was ongoing. The deputy manager role had been offered to a senior staff member already working at the home. Staff were positive about the support they received from this senior staff member and had confidence in them. Staff comments about the provider's representative included, "I think she's great. It's very early days… I respect her." and "Since [name's] come in February, things have started to be put into place." Minutes of the last staff meeting demonstrated staff had been able to speak openly about their experience of working at Three Ashes and their concerns about future management of the home had been addressed.

Further to our feedback on the shortfalls we found at this inspection, job roles and responsibilities for both management roles were timetabled to be agreed the week after the inspection. The culture at the home was open and transparent. Staff, people and their relatives had been kept up to date on the changes planned for the home, including changes to the management team. A meeting had been held at Three Ashes, to discuss these changes with people and their relatives in February 2018. This had been attended by the provider's representative and a company director. People's relatives told us, "The girls [staff] held the fort really well. It [absence of a registered manager] wasn't really noticeable." They told us they had contact information for the provider's "head office" but were pleased the senior staff member had been offered the deputy role as they would, "have someone to go to" on site.

People, their relatives and visiting professionals had confidence in the service provided. Their comments included, "I would recommend it [the home]. I'd say get the first place you can!" and "We are going away for a few days. We haven't been able to do that in a long time." People and their relatives were informed about improvements planned to the home and told us how their ideas were being taken forward.

Staff worked openly with external agencies, including commissioners and the local authority Safeguarding Vulnerable Adults Team. The provider's representative responded positively to our feedback at inspection, providing an initial action plan within two days of the inspection. This demonstrated immediate action had

been taken to address some of the shortfalls we identified. For example, contacting the Gloucestershire Care Home Support Team to arrange staff training. The provider's representative regularly attended meetings of the Gloucestershire Care Provider's association and local meetings relating to activity provision inn care homes and dementia care.

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 17 HSCA RA Regulations 2014 Good governance Governance systems were not sufficiently robust or operated effectively to monitor and improve the safety of the services provided. Accurate and complete records of the care and treatment provided to people had not always been kept.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Appropriate training and supervision had not always been provided to staff to ensure they had the skills and competency to carry out their duties suitably.