

Askham Village Community Limited

Askham House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Askham House is a care home with nursing. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Askham House is one of five care homes on one site, on the outskirts of the village of Doddington. Each home is registered as a separate location. There are some shared facilities such as a café and function room where some activities take place. Askham House accommodates up to 29 people in one adapted building, which reopened in January 2018 following a complete refurbishment. The home provides care to older people and people living with dementia.

At our previous inspection in January 2016 Askham House was rated Requires Improvement. During that inspection one breach of a legal requirement was found. This was because people who used the service were not protected against the risk of their care being delivered without valid and lawful consent. Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the key question, effective, to at least Good.

During the inspection visit on 10 April 2018 we found that this area of the service had improved. People were being cared for in a way that did not deprive them of their rights to liberty and to make their own decisions.

This inspection was carried out earlier than planned as we had received some concerns. These were about the environment and about lack of staffing. We wrote to the provider about both matters and they assured us that any shortfalls had been met. However, during this inspection we found that there were shortfalls in both these areas.

The registered manager had left the home in March 2018. A new manager had been appointed and had been in post for one week when we visited. This new manager had previously been registered to manage this home. A registered manager is a person who has registered with the CQC to manage the home. 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 home is run. The new manager told us she would be applying to the CQC to be registered as manager of Askham House.

There were not enough staff deployed to make sure that people's needs, including social and emotional needs were fully met and people were kept safe.

Staff had received training in safeguarding people. Not all incidents had been recognised as a safeguarding so had not been reported to the safeguarding team. Assessments of a number of potential risks to people had been carried out but some risks had not been assessed or managed successfully.

Staff had not all received up to date fire safety training, in particular in relation to the new building. Staff had

not responded appropriately to a recent fire drill.

Medicines were managed well and people had received their medicines safely and as they had been prescribed. Staff followed infection prevention and control procedures so that the home was clean and hygienic. There was an effective recruitment process in place to reduce the risk of unsuitable staff being employed.

Assessments of people's support needs were carried out before the person was offered a place at the home. This was to ensure that the staff could provide the care and support that the person needed and in the way they preferred. Technology and equipment, such as call bells, pressure mats and hoists were used to enhance the support being provided.

Staff received induction, training and support to enable them to do their job well. People were provided with healthy, nutritious and appetizing meals and special diets were catered for, although people did not always get the support they needed at mealtimes. A range of external health and social care professionals worked with the staff team to support people to maintain their health.

The new building was not being used in a way that met people's needs or promoted their independence. People were generally supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Some staff treated people well and showed empathy and understanding. However, not all staff treated people with kindness and compassion and people's emotional needs were not always recognised or met. People's need for privacy was not always upheld and confidentiality was not always maintained.

Staff made efforts to communicate with people in a way they could understand. Visitors were made to feel welcome.

Care plans gave staff guidance on how to meet people's needs in a personalised way. However, staff were not always made aware of changes to care so people were at risk of receiving unsafe care. Not enough activities, based on people's individual interests and preferences were organised to ensure that people led fulfilling and meaningful lives.

A complaints procedure was in place and advertised so that people would know who to talk to if they had a complaint. End of life care was delivered well, with staff working closely with the GP and community nurses.

Staff were given opportunities to express their views about the service and were aware of their responsibility to deliver a high quality service in line with the provider's ethos and values. A staff recognition scheme was in place, celebrating a 'star of the month' nominated by anyone involved with the home. Staff long-service was rewarded.

Arrangements for people to formally share their views about the home and put forward ideas for improvements were not yet fully in place. Quality assurance processes were in place but were not always robust enough to ensure that a quality service was being provided. These processes had not fully recognised the issues we found during our visit.

The new manager was aware of their responsibility to uphold legal requirements, including notifying the CQC of various matters. The management team worked in partnership with other professionals to ensure that joined-up care was provided to people. There were some links with the local community including a

café that was open to the general public.

Providers will be asked to share this section with the people who use their service and the staff that work there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

There were not enough staff deployed to fully meet people's needs and ensure that people were kept safe at all times.

Staff did not always recognise when an incident needed to be reported to the safeguarding team so incidents were not always reported in a timely manner.

Some risks had not been assessed or managed effectively, putting people at risk. Staff had not responded appropriately to a recent fire drill.

Medicines were given safely and staff followed infection prevention and control procedures to keep the home clean and hygienic.

Requires Improvement ●

Is the service effective?

The service was not always effective.

The new building was not being used effectively to meet people's diverse needs.

People were not always supported effectively with their needs to eat and drink well.

Staff received training and support to enable them to carry out their roles.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Staff did not always treat people with kindness and compassion. People's need for privacy was not always met. Confidentiality was not always upheld.

Requires Improvement ●

Staff made some efforts to communicate with people in a way they could understand.

Visitors were made to feel welcome. Confidential information was stored securely.

Is the service responsive?

The service was not always responsive.

Staff were not always aware of changes to people's care so care delivered was not always as up to date as it should have been.

There were not enough activities delivered, based on individual interests and preferences, to keep people occupied and their minds stimulated.

Care plans gave staff guidance on how to meet each person's needs in the way that person preferred.

End of life care was delivered well.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

The quality assurance system was not robust enough to fully recognise areas where improvements were needed.

Arrangements for people to formally air their views and put forward ideas for improvement were not yet fully in place.

Staff were aware of their responsibility to provide a high quality service in line with the provider's values and ethos.

A staff recognition scheme was in place and staff had opportunities to express their views about the service being delivered.

Requires Improvement ●

Askham House

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 home, and to provide a rating for the home under the Care Act 2014.

This comprehensive inspection included an unannounced visit to the home on 10 April 2018. The visit was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of using, and caring for someone who used a range of health and social care services.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about. We did not ask the provider to submit a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This was because we carried out the inspection earlier than we had planned.

During our visits we observed how the staff interacted with people who lived at Askham House. We spoke with six people who lived there, five relatives of people who lived there and 11 members of staff: three care workers; two housekeeping/kitchen staff; two nurses; a member of the activities team; the new manager and one of the directors. We looked at five people's care records as well as other records relating to the management of the service. These included records relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Following the inspection visit we wrote to a number of external health and social care professionals who the new manager told us had regular contact with the home. Several of the external professionals who replied told us they no longer had any contact (due to them changing jobs) with the home. Three external professionals responded to our questions and their comments have been included in this report. We also contacted the local authority contract monitoring and safeguarding teams and the fire safety officer. On 18

April 2018 the new manager sent us further information that we requested.

Is the service safe?

Our findings

Most people told us they felt safe living at Askham House. One person told us, "I know staff are there...I feel safe and looked after." Another person said they felt safe because "there is always somebody about." Relatives agreed. One relative told us they felt their family member was safe because they "have more care than when they were in hospital...there is someone around all the time." Another relative said, "My [family member] is safe here...it is very good and [family member] is being well looked after." However, one person told us they did not feel safe "because people wander in and out." We saw a person walk into this person's bedroom uninvited.

The provider had systems in place to safeguard people from abuse and avoidable harm. One person told us that staff had never raised their voices or hurt them, even accidentally. Two relatives told us they felt their family member had not been mistreated in the home. Staff had undertaken training in safeguarding people and most staff showed us that they understood what they should report and to whom. Care staff and ancillary staff said they reported to the lead nurse or the new manager. One member of staff said, "If anything's not right, I'd report it. [The training]'s made me more observant." The lead nurse told us they made referrals to the local safeguarding team and completed notifications to CQC. However, the lead nurse had not reported an incident that had occurred the day before our inspection. The lead nurse had not viewed this as an incident to be reported to safeguarding, even though a person had been injured. The new manager agreed that this incident should have been reported and not left until the following day when the new manager was on duty. This meant that incidents that required referral to the safeguarding team had not always been recognised and therefore had not been referred to safeguarding in a timely manner.

The provider had a risk management system in place to try to make sure that risks were managed and minimised, whilst ensuring that people had choice and maximum control over their lives. Potential risks to each person had been assessed and guidance had been put in place for staff so that they would know how to reduce the risks. Potential risks included falls, pressure areas, malnutrition and people's lack of mobility. One person's risk assessment stated they required a full hoist and two staff for all manoeuvres. The assessment gave clear details about why a particular type of sling should not be used. However, we saw that not all risks were managed as well as they should have been. One person who lived with dementia liked to walk around and this included walking into other people's bedrooms. One person told us how scared they were by this. The day before our visit, another person had received bruising to their arm when this person had grabbed them while they were in bed.

The provider had procedures in place relating to fire safety. Following the inspection the new manager sent us a copy of the provider's Fire Safety Policy. This was a policy that covered all buildings on the Askham Village Community site and did not give specific instructions relating to Askham House. For example, it did not explain where the designated assembly point was located nor how to evacuate people if they were upstairs. The policy had not been completed to give full details of contractors to be called in an emergency.

One member of staff said they had not had any fire safety training specific to Askham House since returning to the new building at the end of January 2018 and they did not know where the fire extinguishers were now

located. They also said that almost all staff had ignored the fire alarm the last time it had been activated. This was confirmed at the staff meeting by the director, who had added fire safety to the agenda because staff had failed to respond to the last fire drill in a timely manner. Each person had a Personal Emergency Evacuation Plan (PEEP) in place which gave detailed information about assistance the person needed if they had to be evacuated.

People, relatives and staff had mixed views about whether or not there were enough staff to support people's needs. People did not express any concerns, although they felt staff did not have time to stop and chat to them. One person told us that they had not waited long on the rare occasions they had used their call bell, which they felt meant there were enough staff. Staff comments included, "There's enough when they're all here [and not off sick]"; "It does work, but I'm concerned for when [the home is] full"; "Sometimes I think they could do with one more [care assistant]"; and, "Sometimes enough staff, sometimes not enough."

The provider had a dependency assessment tool to calculate the number of staff needed. This did not appear to take into account the layout of the building. The new manager recognised, as we did, that there were not enough staff deployed to ensure that people living with dementia were properly supported. A member of staff told us that when the staffing level had dropped on one afternoon the previous week, people living with dementia had not been adequately supported. The two staff on duty upstairs had been assisting one person in their room so there were no other staff supervising the other people. This had resulted in an incident in which a person had "stripped off" in the dining area, which had greatly upset another person living at the home. The incident had been undignified and embarrassing for the person themselves and for the other person who had seen what had happened. A member of staff said, "It's not fair on either of them." The new manager said, "We need staff upstairs to divert people whose behaviour challenges others." We concluded that there were not always enough staff deployed effectively to meet people's needs in a timely manner and to keep people safe.

Staff recruitment included thorough checks of potential staff, who had not been allowed to start work before the results of the checks were returned and were satisfactory. Checks included references from previous employers and a criminal records check. Staff had received training in topics that enabled them to keep people and themselves safe, such as moving and handling and the use of equipment to assist people to move.

People were happy that the staff looked after their medicines for them and they were satisfied that they received the right dose of each medicine at the right time. We checked how medicines were managed. Staff had signed medicine administration record charts correctly to show that each medicine had been given, or they had used a code to explain why a medicine had not been given. Numbers of tablets remaining in the packets we checked tallied with the records, indicating that people had been given their medicines as they had been prescribed. We asked the nurse to check with the GP whether people were being given thyroid medicines at the right time, as the GP had not specified giving them at least half an hour before other medicines. Clear protocols were in place so that staff knew when to give people medicines prescribed to be taken 'when required'. The protocols included other actions that staff could try before giving people medicine to calm them. We noted that for one person the record of when they had had topical creams applied was incomplete, making it difficult to be sure that the creams had been applied.

People said that the home was kept very clean. There were procedures in place to make sure the home was clean and hygienic and housekeeping staff were clear about their role in preventing the spread of infection. Personal protective equipment such as disposable gloves and aprons were used appropriately. One person confirmed that staff always wore gloves and aprons when attending to personal care. Staff knew about

using fresh water and which colour mops and buckets should be used for the different areas. A relative told us that their family member's room was always clean and that staff wore gloves and aprons when serving lunch. This showed that the staff followed the provider's procedures to prevent the spread of infection.

Accidents and incidents were recorded. Issues were discussed at Board level as well as during team meetings and handovers. The new manager told us that action plans were drawn up so that lessons could be learned and improvements achieved.

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.

During our inspection on 26 January 2016 we found that the provider was in breach of Regulation 11 Health and Social Care Act Regulations 2014. This was because people who used the service were not protected against the risk of their care being delivered without valid and lawful consent. During our inspection visit on 10 April 2018 we found that improvements had been made. Staff had received training relating to the MCA and DoLS and had a better understanding of the ways in which the legislation related to their everyday work. They gave people choices in as many aspects of their lives as possible and asked people's consent to carry out care tasks. The new manager told us that at the time of the inspection there were a number of people living at Askham House who did not have the capacity to make their own decisions. Assessments of people's capacity had been carried out and recorded in their care records. Best interests decisions had also been recorded. For example, an assessment relating to a person's capacity to understand why they needed to take their prescribed medicines had concluded that the person did not have capacity to make this decision. A best interests decision had been made, involving the GP, the person's relative and staff that the person should be given their medicine disguised in their food (covertly).

Applications had been made to the local authority for DoLS authorisations: the new manager told us they would be reviewing these to make sure that an application had been submitted for every person whose liberty was being restricted. This meant that people's rights in this area were being upheld.

Although Askham House had recently undergone a major refurbishment programme, the building was not being used in a way that met people's diverse needs and did not promote people's independence. The intention was that the ground floor and first floor were self-contained units, each with their own lounge, dining and kitchen areas. The lounges were in the old house and the dining/kitchen areas in the new part. However, the old house was on a different level to the new extension, and there were three or four steps between them. Corridor doors remained shut, with coded locks, so that people were not at risk from the steps. A lift had been installed that took the different levels into account, but most people were not able to operate the lift independently. Even if they had been able to operate the lift, they could not get through the locked doors without staff support. This meant that people were not able to independently move from one area to the other. We saw that for much of the day people sat on upright chairs in the dining areas and did

not use the lounges.

People's needs were assessed before they were offered a place at the home. The information from the assessment formed the basis for the person's care plan. Although people we spoke with could not remember the assessment process, one person told us that staff had always "seemed to know what they were doing." Technology in the form of call bells was available throughout the home. Additional technology, such as pressure mats to alert staff if a person had entered or left a room, or got out of bed, was available for people whose needs indicated they would benefit from this type of assistance.

New staff underwent an induction when they first started work at Askham House. They were supported by a mentor who was a member of staff who had been awarded a level three national vocational qualification. Induction included training in a range of topics so that new staff were equipped to do their job as well as possible. One person told us, "There was a new [staff member] in this morning – [they] knew what I needed."

Further training relevant to their role was offered to all staff, including refresher training in line with the provider's policy. Staff had started to receive classroom training from a trainer employed by the provider, but this member of staff had recently left. Staff said that training was available as on-line training on the computer. The training was followed by a test, which had to be completed correctly to show that the individual had understood and learnt about the topic. A senior member of staff explained that a training matrix was in place, which showed who had done which courses and identified when each staff member needed to refresh their training. Staff were notified of any training they needed to do and were expected to complete the training. Staff told us and the new manager confirmed that most staff were up to date with most of the training. One relative told us, "The staff do a good job." Another relative said they believed staff had the right skills and added, "They seem to know what they're doing."

Nurses and care staff felt supported by the provider and had felt supported by the previous manager. They were confident that the new manager would also be supportive. The new manager told us that they worked 'on the floor' with staff because they needed to know what was going on. They also had the ethos of, "I'll walk in your shoes before I dictate what I want you to do." Housekeeping/kitchen staff told us they also felt supported by their manager and received adequate training opportunities. Senior staff said that they discussed training with staff in supervision sessions and checked what the member of staff had learnt from any recent training courses they had undertaken. This meant that people were supported by a staff team who received training and support to do their job well.

The majority of people were offered a choice of meals. At lunchtime, there was a choice of two main courses or people could request an alternative such as a salad, a jacket potato or an omelette. One relative told us that their family member was no longer able to make choices so they had advised staff on the food their family member preferred. People who required a soft or liquidised diet did not get a choice: the choice for their food was made by the chef. On the day we visited the meal looked appetising and nutritious and people told us they liked the food. One person said, "Oh we are looked after well with food." A relative, who ate some meals at the home with their family member said, "The food is very good." People confirmed that snacks and drinks were brought to them regularly and were available on request at any time. Special diets were catered for. Food and fluid charts were in place if there were concerns about a person's weight or whether they drank enough. However, we noted that one chart had not been completed consistently and there was no indication of the target amounts that would be considered healthy for this person.

One person told us that they preferred to eat in the dining area and they enjoyed the mealtime experience. In the dining area downstairs, people seemed to be enjoying the occasion and there was a lot of conversation and socialising going on. Upstairs, people were less engaged. Three people were each sitting

alone at a table. One person, who clearly needed assistance from staff with their meal, was not assisted other than one care assistant gave them a piece of broccoli and then moved on. Staff passed by this person several times, eventually removing their almost untouched plate of food. Staff then explained to us that the person would be given their pudding when the medicines were given. This was almost an hour and a half after the person had first sat down at the table to start their meal.

The staff worked very closely with their local GP, who hosted a weekly multi-disciplinary team (MDT) meeting on site. Each of the care homes in the Askham Village Community was allotted a 20 to 30 minute slot to discuss clinical problems and sort out medication queries. This had resulted in nursing staff gaining in confidence, which had led to a reduction in the number of emergency calls made to the surgery. The GP said, "I think we have definitely improved and reduced unnecessary requests through closer team work, trust and valuing one another."

Through the MDT, staff made referrals to a range of healthcare professionals, such as community nurses, speech and language therapist and chiropodist to support people with their healthcare. One external professional told us they were very pleased with the improvements they had seen in staff referring clinical problems appropriately. One person told us that staff arranged for them to see the GP when they needed to and they had their feet attended to by the chiropodist regularly.

Is the service caring?

Our findings

Most people and their relatives told us that staff were good and that they were well looked after. One person sat down next to a member of staff we were talking with. They touched the staff's arm and said, "This lady is alright, she's nice." Another person said that staff treated them with respect and kindness. A relative told us, "This is a lovely place. The staff are very good." One staff member said, "I think the care is very good. The care staff are genuinely caring people... there are a lot of staff who are committed."

Staff showed that they knew each person reasonably well and tried to treat each person in a way that made the person feel they mattered. We saw that one member of the care team in particular had a lovely, caring attitude towards people. They were very warm and respectful in their interactions with people. They gave the person they were talking to time to respond and responded to them every time. An external professional told us, "It is my opinion that the staff, led by [names of three nurses] are very happy and dedicated. They genuinely care for the residents."

However, there were comments about staff which were not so positive and we saw that some staff did not treat people as well as they could have done. An external professional said they were concerned about the attitude, skills and knowledge of some staff who accompanied people to appointments. Staff spent time on their mobile phones instead of interacting with people; staff did not know the person they were with, why the person was there and in one instance did not even know the person's name; and staff did not have a caring or understanding attitude towards the person they were accompanying. During our inspection visit several staff just walked past one person who needed support with their meal and a senior member of staff did not speak to anyone other than a relative when they walked into one of the dining areas. One person told us that staff sometimes spoke to each other in their own language, which the person thought was quite rude. One member of staff referred to people who needed a soft or pureed diet as "the blends".

One person told us that they had never heard staff discuss another person in front of them. However, we heard one member of staff disclosing very personal information about a person with their relative in an open, communal area. This meant we could not be sure that confidentiality was always upheld. Records containing personal information were stored securely.

People were offered choices in some areas of their lives. A care assistant told us that people were able to get up whenever they wanted to and have their breakfast when they wanted it. People chose what they wanted to wear and could decide whether or not they wanted to join in any activities that were organised.

However, there were a number of areas in which people did not have choices. Staff told us that when people returned to Askham House following the refurbishment, managers had decided which bedroom each person should have. This meant that no-one had had any choice about how their room was furnished or decorated. At lunchtime, meals were served in the kitchenette from a hot trolley. This included potatoes, vegetables and gravy so people did not have a choice about the quantity of food or how much, if any, gravy they wanted. Staff said one person preferred to eat finger foods. At lunchtime this person was given a meal (not finger food) and, although they did not eat their meal they were not offered any alternatives. People

told us they had not been asked about their preference for male or female carers. People could not independently access all areas of the home so their choices about where they spent their time were very limited.

One person was not wearing anything on their feet. Staff told us that this person did not like wearing their slippers. A member of staff told us, "[Name's] always been like that with slippers ever since I've known [them]." There was nothing to tell us whether or not different types of shoes had been tried to find out whether this person, who could not explain themselves, would feel more comfortable.

Staff respected people's privacy when they carried out personal care, making sure that doors were closed and people were kept as covered as possible. A relative said that personal care was done in a caring manner, preserving dignity. However, people's privacy was not always upheld. One person liked to walk around and entered other people's rooms uninvited. One person showed us how distressed they were by this invasion of their privacy. It also meant their choices could not always be upheld: they would have chosen to keep their bedroom door open so that they could see staff passing but this meant the person could more easily enter their room.

Staff did not always appear to be able to understand people's emotional needs and the emotional needs of the person's relatives. The previous week, one person, because of lack of staff support, had taken all their clothes off in a communal area. We heard a member of staff telling this person's relative about the incident, and laughing. They did not show any understanding of how inappropriate this was, the impact this might have on the relative or how the relative might be feeling.

There were some bedrooms in the old house, behind the code-locked corridor door. Staff were not able to explain why one person, who spent most of their time in bed, was the only person to have been allocated a bedroom in this area. This meant the person was quite isolated. This person liked to talk to staff but staffing levels did not allow them time to stop and talk. Another person also said that staff "never just pop in for a chat, unless they're bringing a drink or supporting with personal care."

People told us that staff encouraged and supported them to be as independent as possible, especially with their personal care. One person said they took care of all their own personal care. However, the layout of the building did not promote independence as people could not access other areas of the home without staff assistance. One person and another person's relatives told us that staff communicated well with people and always explained what they were going to do. Staff told us they were trying to learn different ways of communicating with people who were living with dementia. One relative said staff treated their family member with compassion and kindness and "they talk slowly to [name]." Visitors were always made to feel welcome and were offered drinks and meals if they wanted them. One relative said they always had Sunday lunch with their family member.

Is the service responsive?

Our findings

Each person had a care plan, which gave staff guidance on how to meet the person's needs in a responsive, personalised way. Care plans reflected the person's physical, mental, emotional and social needs. Staff told us that people, and their relatives when the person wanted them to be, were asked to contribute to planning the person's care. One person told us that their family member was involved in planning their care and this person felt they had enough say in their care. Two other relatives said they had never been involved in their family member's care plans. Generally, neither people nor their relatives could remember being involved in planning their care, but they were reasonably happy with the care they received.

A member of care staff told us that they did not get time to read care plans. They said that changes to care plans were discussed "for a couple of days" in handovers but if staff were not on duty for longer than that they missed the changes. They told us this had happened "quite a few times" and gave an example of when someone had started to need re-positioning. The person had not been re-positioned at the correct intervals, which meant there was a risk they could have developed a pressure ulcer.

The provider had an activities team that worked across all five care homes on the site. Notice boards advertised activities that had been arranged and which would be held in one of the homes, in the function room next to the café or in the cinema. Activities and outings included boat trips, a monthly church service and communion. A group of staff had formed a choir called The Sunshine Singers and they led sing-along sessions each month. A gentleman's club met bi-weekly in the 'pub' that had been set up in a room in one of the other homes. The activities coordinator based in Askham House told us they did one-to-one sessions with people and led group activities such as games of bingo. Photographs of people enjoying the activities were on the notice boards.

People had mixed views about the activities on offer. Some people told us there were not enough activities and one person said, "We used to go on outings but we don't seem to do this now." People relied on their relatives or friends to take them out. One person told us they occasionally went to church with their son and would have liked to go more often. A member of staff said, "I wish there was more for [the people living with dementia] to do." They told us that sometimes people were brought downstairs to join in an activity in the lounge, but otherwise there was nothing for them to do. A plan of activities being organised throughout the week was on several notice boards. However, the plan was a week out of date.

The provider had a complaints process in place, which was advertised on notice boards. People knew how to complain but were not sure to whom they would complain. They said this was because they had heard there was a new manager in post but had not yet met them or could not remember who they were. One person said, "If I had a complaint I would just tell [the staff]."

The provider used technology in a number of ways to support care delivery. Each person had a call bell in their bedroom so that they could call staff if they needed to. Equipment such as hoists, hospital-style beds and pressure mats was in place to assist people, and staff, to stay safe.

People were supported at the end of their lives. Each person had an end-of-life care plan in place. One relative told us that staff had discussed this with them as their family member no longer had capacity to make this decision. The staff worked closely with the person, their family, the GP and the community nursing team to ensure that people's wishes were met and they were as comfortable as possible at the end of their life. We saw that Do Not Attempt Resuscitation forms, correctly signed, were in place for people who had chosen not to be resuscitated. The GP told us that end-of-life care plans were completed so that people would be sure that any doctor attending them (such as out-of-hours doctors) would understand their choices, including their preferred place of care. The GP had a MSc in palliative medicine so was well equipped to guide staff. 'Just-in-case' medicines were in place so that there was no delay in getting people the medicines they needed.

The GP told us that when people moved back into Askham House at the end of January 2018, there had been a sharp rise in people being admitted who had been discharged from hospital for palliative care. The nurses and care staff had coped well with the sharp rise in deaths for those leaving hospital with an end-of-life prognosis. In one instance a hospital re-admission had been prevented with the cooperation of staff and management who worked closely with the GP to ensure the person died peacefully, in the care of staff they knew, with their family around them.

Is the service well-led?

Our findings

The provider had a quality assurance system in place. Governance included the Board, comprised of directors and senior managers, that met weekly. Audits of some aspects of the service, such as medicine management, infection control and care plans were carried out by staff of Askham House. The provider employed a Quality Nurse who worked across all five homes. Their role was to carry out their own monitoring to ensure that all audits were completed effectively. They also ensured that action plans were in place to address any shortfalls and that actions were completed. The new manager said that the Quality Nurse "looks from the ground upwards and makes staff keep on top of everything." In spite of this, issues that we found had not been identified or addressed. These included the building not being used in a way that promoted independence and choice and staff not deployed in a way that kept people safe and fully met their needs. Not all records were accurate or fully completed.

People and relatives told us they did not know who the manager was, had not received any written questionnaires to complete and they had not heard about or been invited to any meetings. One person said they thought they could talk to the manager and that they would "say what I think if I didn't like something in the home." The new manager intended to hold quarterly relatives'/residents' meetings and to send out written questionnaires to families and visiting professionals. Comment cards were available in the home's reception area but other opportunities were not yet in place. This meant that the provider did not have a sufficiently robust system in place to ensure that everyone involved with the home was given opportunities to comment and put forward ideas for improvement. Following the inspection the provider told us, "Posters were up in Askham House at the time of the inspection. Relatives meetings are held quarterly and these are notified through posters and through written letters. We can demonstrate that relatives of Askham House residents do attend." They also told us that a feedback box for relatives, people who lived at the home and professionals was in the home's entrance.

Staff were given opportunities to air their views about the home. In February 2018 the provider had sent a written questionnaire to 138 staff of all grades who worked in the five homes on the site and in the shared services that supported the homes, such as maintenance, kitchen, laundry and administration. Responses had been received from 30 staff. When they published the results of the staff survey, the provider wrote, "Overall, Askham is meeting the expectations of the majority. However, there is significant room for improvement."

During the whole service annual staff meeting being held on the day we visited Askham House, the director shared with staff some of the results of the survey. When asked "Are you proud of Askham?" staff's comments included, "Everyone pulled together during the building works" and, "Everyone working as one team across the site." A 'smiles and frowns' box was available in the staff room for staff to make anonymous comments, both positive and where improvements could be made. The provider responded in writing to all comments that were made. They explained how suggestions were going to be followed up, or, if that was not possible, the reasons why not.

A staff recognition scheme was in place, with two separate aspects of celebration. Each month anyone

involved with Askham House could nominate a member of staff for 'star of the month'. Nominations were looked at by the Board and the member of staff with the most compelling nomination was awarded 'star of the month'. Their photograph and some of the words from the nomination were displayed on notice boards in the home. A long-service recognition scheme had been introduced in which staff were presented with a certificate of appreciation and a monetary reward if they had been employed at Askham for five years or more. Eleven staff had worked at Askham Village Community for more than five years. We spoke with three staff at Askham House who had worked 17, 13 and nine years respectively. Staff appreciated the recognition. One member of staff told us, "It's an incentive. Makes you feel you want to go to work."

The provider was in the process of introducing a promotion possibility for care staff. Those staff who had completed a national vocational qualification to level three had been given the opportunity to express an interest in undertaking a 12-month course to become an 'assistant practitioner'. This role would fall between care and nursing and 10 people had been chosen to start the training.

Staff were fully aware of their responsibility to work within the provider's values and ethos of community, empowerment, dignity, respect and quality. The director told staff at the meeting, "The spotlight is on us." Staff were happy to be working at Askham House. One member of staff said, "There's a lot of good [care workers], good staff. We all help each other. Management's really good – you can approach all of them. They've all been so supportive. It's nice to have [name of new manager] back."

The home had received a number of compliments and thank you cards. One person's relative wrote, "Thank you so much for the amazing caring job you did for my [family member] throughout the entire stay. [They] loved being there among you all which is a testament to what a marvellous job you all did. Words can hardly express our gratitude." Another relative had written, "A great thank you for all your kindness. Your support was very much appreciated by [name] and all the family." A healthcare professional told us, "I have seen great improvements in the home. ...In my opinion the service is safe, responsive to individual patient needs, very caring and well-led."

There was no registered manager in post. The new manager had started work at the home a week before our inspection visit. The new manager had previously managed this service. Staff who knew the new manager were pleased with their appointment. One member of staff felt it was helpful that the new manager "knew the ropes." Another member of staff said that although the new manager had only just started, "I know [they'd] get something done." A healthcare professional said, "[The new manager] is a very good nurse...forward thinking and adaptable and I'm sure [they] will make a success of the position." The new manager described themselves as "approachable and friendly" and told us that they work "on the floor" so that they know what's going on. The new manager demonstrated that they were fully aware of their responsibility to work within relevant legislation, including sending notifications to the CQC. Notifications are events in the home that the provider is required by law to tell us about.

There were some links with the local community. People and their relatives, from all five homes, were encouraged to use the café where they could meet other people. The café was open to the general public and a board on the road invited passers-by in. Groups such as the Girl Guides used the function room for their regular meetings. Staff worked in partnership with other agencies such as the local authority and the CCG to provide joined-up care for people.