Carebase (Sewardstone) Limited

Ashbrook Court Care Home

Inspection report

Sewardstone Road
Waltham Abbey
London
E4 7RG

Tel: 02085245530
Website: www.carebase.org.uk

Date of inspection visit:
22 October 2018
23 October 2018

Date of publication:
15 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashbrook Court Care Home provides accommodation and personal care for up to 70 older people, some of whom who may live with dementia and those who have complex nursing needs. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Our previous comprehensive inspection to the service was on 23 and 24 August 2017. The overall rating of the service at that time was judged to be 'Requires Improvement' and no breaches of regulation with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 made.

This inspection was completed on 22 and 23 October 2018 and was unannounced. There were 65 people living at the service.

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

Quality assurance checks and audits were not as robust as they should be, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm and where their health and wellbeing was compromised. Appropriate steps had not been taken to ensure the management team had sufficient oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight at both provider and service level impacted on people, staff and the quality of care provided. The management team were unable to fully demonstrate where improvements to the service were needed, how these were to be and had been addressed; and lessons learned to ensure compliance with regulatory requirements and the fundamental standards.

The management team had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people using the service, we observed other interactions which were not respectful or caring and failed to ensure people were treated with respect and dignity. Not all people using the service received appropriate opportunities for meaningful social activities.

The standard of record keeping was poor and care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's current care and support needs. Where people were judged to be at the end of their life, information relating to their end of life care needs were not recorded and not all staff had received appropriate training. Suitable control measures were not always put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, and risk assessments had not been

developed for all areas of identified risk.

Recruitment procedures required improvement to make sure these were robustly completed for all staff employed to ensure safer recruitment practices. Not all staff had received a robust induction and the role of senior members of staff was not effective in monitoring staff's practice, performance and providing sufficient guidance and support. Training and development was not sufficient in some areas to demonstrate that people's care and support needs were fully understood by staff and embedded in their everyday practice. Staff had not received regular supervision.

People's capacity to make day-to-day decisions had been considered and assessed. Nonetheless, improvements were required to ensure staff had a better understanding of the main principles of the Mental Capacity Act and how to apply these to their everyday practice, particularly relating to choice and consent.

People's healthcare needs were supported and people had access to a range of healthcare services and professionals as required. Medication practices and procedures were generally satisfactory. The service worked with other organisations to ensure they delivered joined-up care. The registered provider's arrangements for the prevention and control of infection at the service was satisfactory.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks were not identified for all areas of risk. Risks were not suitably managed or mitigated to ensure people's safety and wellbeing and improvements were required.

Although the deployment of staff appeared to be appropriate in communal lounge areas, comments from people regarding staffing levels was variable and improvements were required to ensure staff spent time with people to talk and to engage with.

Improvements were required to ensure recruitment procedures were reviewed to ensure these are safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staffs' knowledge and understanding of training was embedded in their everyday practice. Not all staff had received a robust induction or regular supervision.

The dining experience was variable across the service and improvements were required relating to how people's nutritional and hydration intake was recorded so that it could be determined if this was satisfactory or not.

Staff's knowledge and understanding of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS] was basic.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People using the service did not always receive good quality care or always treated with kindness, respect, dignity and compassion. Care provided was primarily task focused.

Staff did not always effectively communicate with people using the service, particularly people living with dementia.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care and support that was responsive to their individual needs.

Improvements were needed to ensure all of a person's care and support needs was recorded and the information up-to-date and accurate.

People were not supported to participate in a range of social activities.

Although a record of complaints was maintained, including internal investigations, people and those acting on their behalf did not always feel listened to or confident their concerns would be taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to measure the quality of the service did not identify the concerns and risks to people that we found as part of this inspection.

The views of people and others were sought about the quality of the service provided, however no responses were completed and forwarded to the service.

Ashbrook Court 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.

The inspection was prompted in part following concerns raised by the Local Authority with the Care Quality Commission. The information shared with the Care Quality Commission indicated concerns about poor care and staff practices and this inspection examined those risks.

This inspection took place on 22 and 23 October 2018 and was unannounced. The inspection team consisted of four inspectors on both days. On 22 and 23 October 2018 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

The registered provider submitted their 'Provider Information Return' [PIR] in July 2018. 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 reviewed the information we held about the service including safeguarding alerts and other statutory notifications. This refers specifically to incidents, events and changes the registered provider and registered manager are required to notify us about by law.

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 10 people who used the service, 14 people's relatives, 12 members of staff [including the deputy manager, qualified nurses, senior staff and care staff], one member of staff responsible for facilitating social activities and the registered manager.

We reviewed 10 people's care plans and care records. We looked at the staff recruitment records for five members of staff, staff training information for the service, supervision and appraisal records for an additional three members of staff. We also looked at the service's arrangements for the management of

medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

Safe was rated as 'Requires Improvement' at our last inspection on 23 and 24 August 2017. At this inspection, we found that safe remained rated as 'Requires Improvement.'

People did not always receive care that was safe. Not all risks were identified, and suitable control measures were not in place to mitigate the risk or potential risk of harm for people living at Ashbrook Court Care Home.

Although staff had received manual handling training, inspectors observed five separate incidents where staff performed unsafe manual handling practices. On three occasions staff placed people at potential risk of harm by placing their hands under people's armpits when assisting them to mobilise. This technique is unsafe, can hurt and cause injury because the person's armpits and shoulders have too much pressure on them. Staff were also observed to assist two people to mobilise using their wheelchair. Although footplates were attached, both footplates on each wheelchair had been swung to the side and out of the way. Neither person's feet were placed on the footplates to ensure their posture was appropriate and comfortable. This technique is unsafe, can hurt and cause injury because the person's feet could drag along the floor and get caught under the wheelchair.

Several freestanding wardrobes were observed to be tilting forward with a gap between the top of the furniture and the wall of approximately five to 10 centimetres [estimated], tapering to a negligible gap at the bottom. In several instances the tilt was significant, causing the drawers at the base of the furniture to fall open and fail to close and was particularly noticeable within two bedrooms. None of the wardrobes viewed, except for one, had a retaining bracket to prevent the furniture falling, or being pulled forward with a potential to cause significant injury and harm. The registered manager was advised that a review of all rooms where wardrobes were located required appropriate remedial action taken to ensure peoples' safety and to mitigate any such risks. On 8 November 2018, we emailed the registered manager to find out what action had been taken. They confirmed that remedial action was initiated the day after the inspection, with four people's wardrobes left to do.

One person was observed to have their bedrail up with full length foam bedrail bumpers in use whilst they were in bed. Although records available suggested there had been no accidents or incidents relating to this person having this item of equipment in place, a risk assessment had not been completed to determine this was suitable or the rationale behind the decision to have this in place. A bedrail assessment had not been completed to determine the bedrails were suitable for the individual person so that any risks identified were balanced against the anticipated benefits. Another person's care plan referred to bedrails not being suitable as this could place the person's safety at risk. However, the daily care records showed these were used on two occasions despite the bedrails not being safe. We discussed this with the registered manager and they told us they had not been made aware of the latter.

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

People's comments about staffing levels were variable, particularly at weekends. One person told us, "Weekends, not as many staff on, you wander to look for someone, less staff on." Another person remarked on the high turnover of staff, staff not being sufficiently attentive and staff they knew had left the service's employment. A third person told us, "All the good staff have gone and there is not enough staff." They further stated they had to wait for staff to get them up in the morning and this could mean waiting for up to an hour. They told us, "I asked them to get me up an hour ago and still not happened, happens all the time, staffing is unbelievable." People told us the impact of insufficient staff, particularly at weekends, meant they had to wait for long periods of time for their comfort needs to be met and, in some instances, these had led to 'accidents' whereby their clothing became wet. The above was echoed by people's relatives. One relative told us, "Never enough staff especially weekends when they [organisation] use agency."

The deployment of staff in communal lounge areas was seen to be appropriate, however concerns were raised with the registered manager about people who predominately remained in bed and the lack of meaningful observations carried out to ensure their wellbeing. People on Birch and Redwood Unit did not receive their lunchtime meals in a timely manner. It was unclear if this was due to insufficient staffing levels or if this was due to a lack of organisation at these times. The service's staffing levels were determined using a specific tool to assess a person's activities of daily living. Although people's individual dependency needs were recorded each month and the total hours required, calculated, this did not consider the specific number of hours required for each unit or the layout of the environment. Information provided following the inspection showed that staff's response time for people varied from as little as one or two minutes to over an hour, particularly in the evenings or during the night. There was no evidence to show this had been monitored and picked up by the organisation and what was being done.

Staff recruitment records for four members of staff were viewed. Not all relevant checks had been completed before a new member of staff commenced employment at the service. There was no completed application form for one member of staff employed in August 2018. This meant there was no information available to provide evidence of a full employment history, together with satisfactory explanation of any gaps in employment or satisfactory evidence of relevant qualifications. Additionally, only one written reference had been pursued and a written record was not completed or retained to demonstrate the discussion had as part of the interview process and the rationale for the staff member's appointment. A full employment history had not been sought for a further two members of staff. The gaps in employment had been identified by the registered provider prior to the inspection and were in the process of being corrected.

One staff member's Disclosure and Barring Service [DBS] certificate was received six days after they commenced employment at the service. New members of staff who work with adults can begin work before their DBS certificate has arrived but this should only happen if the safety of people using the service would be put at risk if the person did not commence employment. The 'Adult First' check is a service that allows an individual to be checked against the adults' barring list while waiting for the full DBS check to be completed. No rationale to demonstrate the reasons for not waiting for the full DBS check had been completed. Following the inspection the registered provider wrote to us and confirmed the staff member had been supervised.

A record of safeguarding concerns was maintained. However, actions taken relating to the investigations of safeguarding concerns were not routinely recorded, including telephone calls with the Local Authority and actions taken as part of the service's own internal investigation. Although staff were verbally able to demonstrate a satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to the management team and external agencies, such as the Local Authority and Care Quality Commission, this did not always happen in practice. For example, the records for one person noted a large bruise on their

chest and breast, which staff were unable to provide a rationale as to how this had happened. Neither the registered manager nor the residential lead for the service were aware of this and an incident report had not been completed by staff. This suggested staff did not recognise the importance of this incident and report it to a senior member of staff for consideration under safeguarding procedures.

The medication rounds were evenly spaced out throughout the day to ensure people did not receive their medication too close together or too late. Observation of staff practice showed staff undertook this task with dignity and respect for the people they supported. We looked at the Medication Administration Records [MAR] for 14 of the 65 people who resided at the service and these showed each person had received their medication at the times they needed them and records were kept in good order. Minor improvements were required to ensure PRN 'as required' protocols were completed for all medicines to detail the specific circumstances this should be administered.

People were protected by the prevention and control of infection. The service's infection control and principles of cleanliness were monitored and maintained to a good standard. The premises were clean, odour free and staff used appropriate Personal Protective Equipment [PPE], such as gloves and aprons. Staff told us and records confirmed staff received suitable infection control training and understood their responsibilities for maintaining appropriate standards of cleanliness and hygiene; and followed food safety guidance.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as 'Requires Improvement' at our last inspection on 23 and 24 August 2017. At this inspection, we found that effective remained rated as 'Requires Improvement.'

The training plan provided demonstrated most staff had attained mandatory training in line with the registered provider's expectations. Although our observations showed some staff were effectively able to apply their learning, others were not, and improvements were required to ensure their training was embedded in their everyday practice, for example, in relation to manual handling, dementia awareness and communication. Not all staff's interactions, exchanges and communication with people using the service was observed to be appropriate. These exchanges, particularly for people living with dementia were primarily routine and 'task-led'. This referred specifically to the provision of drinks, providing people with food and drink and assisting people with personal care.

There was evidence to show staff newly employed at Ashbrook Court Care Home had received an 'in-house' orientation induction. However, not all inductions were dated or signed by the employee to confirm their induction was completed. Additionally, two out of three agency members of staff utilised at the service did not have evidence of an induction having been completed.

Staff spoken with told us they did not feel valued or supported by the organisation or the registered manager at Ashbrook Court Care Home and morale was low. Staff commented they did not feel the registered manager actively listened to what they had to say. Although the registered provider's expectation was that staff should receive regular formal supervision, records viewed showed this had not always happened. The records for three members of staff showed they commenced employment in July and August 2018. None of these staff had received supervision. Another member of staff who was employed in January 2018, had only received supervision in February and May 2018.

People's comments about the quality of meals provided were variable and so was our observations of their dining experience. Positive interactions were noted for people living on Oak and Maple Units and the dining experience was seen to be relaxed, friendly and unhurried. One person said, "Food is excellent, full marks to the chef, enough choice, everything is lovely" and another said, "Food is not too bad, lunch was quite nice today." People were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance and support to eat and drink this was provided in a sensitive, dignified manner, were not rushed to eat their meal and were able to enjoy the dining experience at their own pace. Another person told us, "The food is very good" This contrasted with Birch and Redwood Units. With comments such as, "The food is atrocious, give you margarine, you have to ask for butter, makes the food tastier" and, "Today I asked for a boiled egg and got a hardboiled egg and this was cold."

On Birch Unit at lunchtime, two members of staff were observed to stand either side of a dining table that had three people seated. Both members of staff were observed to discuss the merits and pitfalls of seating two of the three people at the same table. Staff appeared oblivious that this was potentially inappropriate and could be insensitive. It did not occur to either member of staff that they should either explain what was

happening or sensitively consider discussing this away from the dining table. One relative was engaged with supporting staff during the lunchtime meal. The relative sat at a table with three people, one of whom was noticeably having difficulty supporting themselves to eat. The relative reacted by jumping up quickly and demonstrating how the person should use their spoon and dip bread into their soup. Staff did not intervene when the relative handed out the bread, by hand, broke the bread into pieces, dipped in into their individual soup bowls and raised it to their mouth asking them to eat it in turn. Only when the senior member of staff noted the inspector watching was a member of staff instructed to provide support.

On Redwood Unit, little verbal interactions took place between staff and people using the service. On the second day of inspection, although staff tried to offer people meal choices, this did not work easily as some staff members seemed unsure of what to do. For example, bread was offered with the main meal, rather than with the soup and staff were unsure of the names of the foods being served. One person was asked what they would like to drink but only shown a carton of orange juice. Although the qualified nurse tried to ensure each person in the dining room had eaten something, limited time was given by staff to prompt and encourage them to eat. This was because staff were busy taking meals to people in their rooms. While the lunchtime meal commenced at 12.30, on both days of inspection, the last person on Redwood Unit received their meal at 14:00, one hour 30 minutes after the first person.

The nutritional needs of people were identified and where people who used the service were at nutritional risk, referrals to a healthcare professional had been made. Where instructions recorded that people should be weighed at regular intervals, such as monthly, this had been recorded and followed. However, it was not possible to establish if people had received sufficient food and fluid on any given day so as determine if their diet was satisfactory as the records were inconsistently completed. For example, the care plan for one person stated they should be offered a milkshake twice daily, however for the period 16 to 22 October 2018, no information was recorded detailing if the person was offered this or was offered and refused the milkshake.

The service worked with other organisations to ensure they delivered joined-up care and support. This included the dementia support team, District Nurse services, local falls team, mental health teams for older people and the local NHS hospital 'step-down' team. The latter refers specifically where people no longer require the level of care from an acute medical setting such as a hospital but are not ready to return to their own home. This was particularly apparent where people's healthcare needs had changed, and they required the support of external organisations and agencies to ensure people's welfare and wellbeing.

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 the mental capacity to make 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.

Staff demonstrated a basic knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Information available showed people living at the service had had their capacity to make decisions assessed. Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

Caring was rated as 'Requires Improvement' at our last inspection on 23 and 24 August 2017. At this inspection, we found that caring remained rated as 'Requires Improvement.'

People's and relatives' comments about the quality of care provided at Ashbrook Court Care Home were variable. Where positive comments were recorded these were from people on Oak and Maple Units on the ground floor. Comments included, "Staff do really well, they are cheerful, very helpful, do utmost to oblige." Another person stated, "The staff are very good, they sing to me and I sing, its lovely." Where relatives' comments were favourable, they told us staff cared for their family member to a good standard. One relative told us, "[Name of person using the service] is fine but good staff seem to leave, the staff are lovely."

However, this contrasted with other comments received. Primarily people told us staff did not have the time to sit and talk with them, there were insufficient staff to meet their needs and there was a high usage of agency staff. One relative told us they were worried that their member of family would not get the appropriate care they needed if they did not visit the service most days. They told us, "We don't have confidence in the home." Another relative alluded to the care and support being provided for their family member as "rubbish" but stated they did not want to move them to another care home as they did not want to unsettle them.

Staff's practice and behaviours were not always caring or person-centred. Whilst some staff's interactions were observed to be kind and caring, and staff engaged with people in a meaningful and helpful way, most interactions were task and service-led and not all effectively communicated with the people they supported. On Oak and Maple Units, one person who did not speak English was supported to access the garden. The staff member tried hard to interpret what the person was trying to convey. They looked at the flowers together, the person living at the service picked a flower and the staff member suggested the person place this behind their ear. The person smiled and appeared very content with this activity and interaction.

On Birch and Redwood Units, interactions solely related to staff providing drinks, giving people their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television and although this was on throughout the day, people using the service were predominately either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time and staff interactions did not always ensure people got the time they needed to respond before staff walked away.

We were not assured that staff always understood the importance of giving people choices and how to support people that could not always make decisions and choices for themselves. For example, people were observed not always being offered choice in relation to drinks. Not all people were able to communicate their specific wishes and preferences relating to the meal choices available, particularly people living with dementia. The menu was not displayed in an appropriate format and people were not physically shown the meal choices available to enable them to make an informed choice.

Staff's practice did not always ensure people using the service were treated with respect, dignity or consider people's preferences. Relatives spoke of their member of family wearing another person's clothing because the laundry arrangements at the service were poor. One relative told us, "Clothing has been a nightmare, [relative] had got no underwear, even though they have lots of clothes, there were none left. Last Monday or Tuesday, everything they had on was someone else." Some members of staff were observed over both days of inspection to stand up whilst assisting people to eat rather than sit down beside them. As already stated, staff were seen and overheard to speak loudly and across the dining room or communal lounge area about individual people.

Where people could engage [Oak and Maple Units], their independence was promoted and encouraged according to their capabilities and abilities. People told us they could manage some aspects of their personal care with limited staff support. They also confirmed if they needed assistance this would be provided. The majority of people were able to eat and drink independently.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed there were no restrictions when they visited and they were always made to feel welcome by staff.

Requires Improvement

Is the service responsive?

Our findings

Responsive was rated as 'Requires Improvement' at our last inspection on 23 and 24 August 2017. At this inspection, we found that responsive remained rated as 'Requires Improvement.'

Not all people living at Ashbrook Court Care Home received care that was personalised and responsive. This was particularly evident for people residing on Birch and Redwood Unit on the first floor. Staff did not always engage with people in a positive way and care on both days of inspection was task-led. People did not always have control over their day-to-day lives, for example, where they were seated during the day and the length of time they remained sat in the same chair. On day one of the inspection, one person on Redwood Unit was seen to be seated on a hard dining chair at the dining table between 10:30 and 17:40. During this time the only interaction they received was to be given their breakfast, mid-morning snack and drink, lunch, mid-afternoon snack and drink and teatime meal. Staff provided very little interaction and support for this person. Albeit slowly they were noted to eat for a continuous period of seven hours and 10 minutes. Staff working on Redwood Unit did not consider the person may like to sit away from the dining table in a comfortable chair between meals, may require support to have their comfort needs met or that they may have required prompting and/or assistance to eat their meal. No other interactions by staff were offered to this person and demonstrated the only care and support provided to them was solely task orientated.

People were very complimentary about one of the two lifestyle coordinators employed at Ashbrook Court Care Home. One relative told us, "Wonderful activities lady, very caring and knows them [people using the service] well. The atmosphere is different when she is around and includes all the residents." One person using the service told us, "My choice if I want to be lazy or not and stay in bed, go to the lounge and sit and talk. I enjoy the exercise classes and chatting. The level of meaningful activities provided to people across the service was variable.

On the first day of inspection, between four and six people at any one time were seated within the communal lounge on Redwood Unit between 10:30 and 17:40. Up until lunchtime, no opportunities were provided for them to participate in meaningful social activities. Although two lifestyle coordinators are employed at Ashbrook Court Care Home to facilitate social activities, one was downstairs as some people enjoyed an external entertainer [Elvis impersonator]. On Redwood Unit, at 12:30 a lifestyle coordinator entered the communal lounge and put on some music for people to listen to whilst they ate their meal. Having done this the lifestyle coordinator left the communal lounge. Three hours later the same lifestyle coordinator returned, put on a CD and then left. No verbal interaction was had with the five people present and when the CD finished a member of staff put on the television without consulting anyone. This evidenced no meaningful activities or interactions were held with people on Redwood Unit. There was a complete lack of engagement and understanding for people with more complex needs, including those living with dementia. Following the inspection the registered provider wrote to us and advised 10 out of 32 people saw the external entertainer, with 13 others having some form of activity, including people in their rooms having one-to-one interactions. This did not concur with the inspectors' findings.

People's care records were recorded within an electronic care planning system and staff chose specific sentences from an available list of stock sentences. This was not individual or personalised and care plans viewed did not fully reflect people's holistic care and support needs or provide sufficient guidance for staff as to how people's needs were to be met. Improvements were needed to ensure care plans included accurate, personalised information relating to a person's specific care needs and the delivery of care to be provided by staff. This meant there was a risk that relevant information was not captured for use by care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered.

The care plan for one person recorded they had a catheter in place. This was confirmed as accurate by the service's residential lead, daily care records verified staff emptied the person's catheter at regular intervals and catheter bags were evident within the person's room. A care plan relating to the person's catheter needs was not completed detailing the type of catheter used, if the catheter in place was for short-term or long-term usage and the associated risks, such as blockage or risk of infection. Daily care records for the same person recorded the person experienced discomfort and pain during manual handling transfers and when personal care was provided. A care plan detailing the level of pain experienced, such as its location, frequency, severity of pain and how this was to be managed by staff, was not recorded. The residential lead confirmed the same person was at nutritional risk. A care plan relating to their nutritional needs and formal nutritional risk assessment was not completed.

Staff told us there were two people using the service that were judged as requiring end of life care, however the registered manager told us only one person required end of life care. Neither person had an end of life care plan in place, including advanced decision directives. The latter sets out if the person has expressed a wish to be cared for at the service or to go to hospital and if potential treatment options have been discussed with the person's GP or relevant healthcare professionals. No information was recorded relating to pain management arrangements and how the person's end of life care symptoms is to be managed to maintain the person's quality of life as much as possible. Although there was no evidence available to suggest either person was not receiving appropriate care, not all staff had received end of life care training. The registered manager and area manager confirmed the Gold Standard Framework was to be introduced to the service in 2019 and would include staff training.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all relatives felt the registered provider or manager listened to them or took their concerns seriously. One relative told us, "Lack of communication from the top, they never reply to our emails. I would speak to the manager and they would say I have spoken to the residential lead. We did not have any feedback and there is a lack of communication between the manager and relatives in replying to our concerns." Another relative told us, "Several relatives on this floor [Birch] have been involved in various complaints." Following the inspection the registered provider wrote to us and told us complaints were addressed at provider level and they actively involved themselves in complaints, including meeting with complainants.

The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service. A record of each complaint was maintained, however, improvements were required to ensure a clear record of the investigation was evident, including interviews with staff and actions taken. For example, one complaint's actions detailed the member of staff's approach and attitude was to be kept under review. There was no record of the interview between the registered manager and member of staff and no evidence to support the member of staff had been monitored. This was discussed with the registered manager and an assurance was provided that the required improvements would be made.

A record of compliments was maintained detailing the service's achievements. Additionally, since our last inspection in August 2017, many reviews had been posted on a well-known external website about the quality of care and facilities at Ashbrook Court Care Home. These were positive and rated the care home highly.

Inadequate

Is the service well-led?

Our findings

Well-led was rated as 'Requires Improvement' at our last inspection on 23 and 24 August 2017. At this inspection, we found that well-led had deteriorated and was now rated as 'Inadequate.'

Although there were many audits and checks in place which were completed at regular intervals to inform the registered manager's monthly report, these checks had failed to identify and address the concerns found as part of this inspection. Audits relating to medication and care planning were completed at regular intervals, however where issues were highlighted, an action plan detailing how these were to be addressed was not always completed.

This was because there were inadequate arrangements in place to effectively monitor the quality of the service, ensure that the service was operating safely, and lessons learned when things go wrong. It was apparent from our inspection that the lack of robust quality monitoring and auditing was not as effective as it should be to recognise breaches or potential breaches with regulatory requirements.

The quality assurance arrangements failed to effectively measure the experience of people being supported and cared for at Ashbrook Court Care Home. This meant there was a lack of oversight based on observations of actual care being provided by staff and being experienced by people living at the service. Staff practices were not monitored to ensure people were always being treated with the utmost respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.' And there was a lack of effort made by the management team since our previous inspection in August 2017, to address the poor interactions, lack of personalised care being received by people residing within Birch and Redwood Units and care planning arrangements.

The culture of the service was not positive, open, transparent and well-led. Relatives of people living at Ashbrook Court Care Home told us the service was not consistently well-led and that the leadership at the service was inconsistent. Relatives told us they rarely saw evidence of the registered manager monitoring the quality of care provided at the service. They confirmed they never saw the management team checking things were running smoothly. Some relatives felt "defeated" by the management team, because their concerns and complaints were not listened to. They confirmed they had raised issues with the registered provider and manager and little action was taken to address their concerns.

We asked the registered manager if they conducted a regular 'walk-around' of the service to familiarise themselves as to what was happening within the service. The registered manager confirmed they did but no records were presented or available to demonstrate this. Nine out of 10 members of staff spoken with told us the registered manager rarely completed a 'walk around'.

The registered manager acknowledged not all required improvements following the last inspection in August 2017 had been addressed. The rationale provided was that the service had been without an administrator and clinical lead for some time and there had been challenges with the recruitment of staff. The provider had not ensured any additional support was provided during this time to enable effective and

ongoing improvement.

We asked the registered manager as to the formal support they received. The registered manager confirmed the business manager visited the service at regular intervals and was contactable via the telephone and email, however the registered manager had not received formal supervision since May 2018. This was concerning given the level of scrutiny from the Local Authority and Clinical Commissioning Groups and the concerns raised about staff practices and poor outcomes for people using the service in recent months. The registered manager confirmed they had raised several concerns directly with the registered provider and monthly reports were now being submitted to the managing director of the organisation, human resources manager and the business manager. But this has not as of yet resulted it any positive changes. Following the inspection the registered provider wrote to us. They told us the registered manager was regularly supervised and supported by the business manager. However, evidence to support this was not made available at the time of inspection and did not concur with the registered manager's comments. The registered manager had also had a meeting with the registered provider in June 2018.

The Provider Information Return [PIR] submitted on 10 July 2018 referred to a high turnover of staff, specifically 68 members of staff had left the service's employment in the last 12 months. We requested to see the results from staff satisfaction questionnaires for the period 2017 to 2018. The registered manager told us no responses were received, however staff had the opportunity to post suggestions and any concerns directly to the area manager for analysis. The business manager was asked to provide a copy of this analysis and this showed no staff had posted a suggestion or concern. There was no evidence to show questions had been asked by the organisation as to why there had been a high turnover of staff or why staff were reluctant to engage with the registered provider's quality assurance processes and arrangements. Following the inspection the registered provider confirmed an analysis of why staff left was carried out but it did not provide an explanation for the 'high turnover' of staff.

Staff did not feel listened to, valued or supported by the registered manager and the area manager. A significant number of staff spoken with were candid and expressed real concern regarding the registered manager and their management style. Staff when speaking to inspectors were very concerned about comments made getting back to the registered manager as they feared for their continued employment and were afraid of repercussions. Staff described a "bullying culture" and "culture of fear" which was led by the registered manager. This demonstrated the culture within the service was not positive or open and some people were placed at continued risk of receiving poor care because staff did not feel confident and empowered to speak out when things go wrong.

Staff meetings had been held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Minutes of the meetings confirmed this and demonstrated the last meeting was held on 10 August 2018. Although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine how these were to be or had been monitored and the issues addressed. For example, concerns about staff's practice relating to manual handling and staff's attitude towards people using the service was highlighted as a concern. No information was recorded detailing how this was to be monitored and addressed.

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

People using the service and their relatives had been given the opportunity to complete an annual satisfaction survey in November 2017. The registered manager advised no report was completed as only one person using the service and 16 out of 43 relatives had responded.

Meetings for people using the service and those acting on their behalf were held at three monthly intervals in the afternoon or evening, with additional weekend 'Drop in Sessions' available for people to meet the registered manager. The last meeting for people using the service and those acting on their behalf was in September 2018. The meeting minutes showed three people and four relatives attended the meeting. It was unclear if any positive changes had been made as a result of these regular meetings or how it drove improvement in the service.

Information available showed the service worked in partnership with key organisations to support care provision and joined-up care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Each person must have a plan of care detailing the care and treatment to be provided by staff.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments must be completed for all areas of risk and to include plans for managing risk.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate and effective arrangements must be in place to assess and monitor the quality of the service provided.

The enforcement action we took:

Impose a condition.