Enter and View

ASHBY HOUSE

22nd May 2025

healthwatch
Milton Keynes

1 Contents

2 Introduction

2.1 Details of visit

Name of home	Ashby House Nursing Home
Service provider	Barchester Healthcare Homes Ltd
Date and time	22nd May 2025 between 9.30am and 4.30pm
Authorised representative (s)	Helen Browse & Sarah Hibble

2.2 Acknowledgements

Healthwatch Milton Keynes would like to thank the service provider, staff, service users and their families for their contribution to this Enter and View visit, notably for their helpfulness, hospitality, and courtesy.

2.3 Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time of our visit.

3 What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists, and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first-hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer, they will be directed to the Care Quality Commission where they are protected by legislation if they raise a concern.

3.1 Purpose of visit

The purpose of this Enter and View programme was to engage with residents, their relatives, or carers, to explore their overall experience of living Ashby House Care Home. As well as building a picture of their general experience, we asked about experiences in relation to social isolation, physical activity, and the experience of those residents with additional communication needs.

3.2 Strategic drivers

Healthwatch Milton Keynes will be working in partnership with Milton Keynes Council, undertaking aligned visits, as well as continuing our independent programme of visits, so that a well-rounded view of the operation of the care home/service can be understood. Healthwatch Milton Keynes will be specifically focusing on the experiences of the services users and their loved ones.

Social isolation and/or loneliness has been recognised as having an impact on people's physical health and emotional wellbeing. COVID 19 increased and intensified loneliness and isolation by the very nature of the way in which we had to manage and reduce the spread of the virus.

It is important to understand the distinction between loneliness and isolation. Age UK defines 'isolation' as separation from social or familial contact, community involvement, or access to services, while 'loneliness' can be understood as an individual's personal, subjective sense of lacking these things. It is therefore possible to be isolated without being lonely, and to be lonely without being isolated. There is a link between poor physical health and increased isolation as loss of mobility, hearing or sight can make it more difficult to engage in activities. It is, therefore, important to explore how residents of care homes in Milton Keynes are able to access physical activity alongside social activity.

Healthwatch Milton Keynes sees the legacy the COVID 19 pandemic has left on both services, and service users alike. We understand that the effects of the pandemic have been long-lasting and there are continuing pressures on the wider services that support Care Homes.

It is our intention to be able to formally report the impacts of these on both services and those who use the services and their loved ones as part of this year's Enter and View Programme.

4 Overall summary

The single-storey, purpose-built home sits at the end of a quiet cul-de-sac, with pleasant gardens and courtyard views enjoyed by many residents. The layout is simple and accessible, though smaller rooms make hoist use difficult, limiting time out of bed for some. Bedrooms include toilets but no ensuite showers; bathing facilities are shared.

The décor is clean but dated, and dementia-friendly design elements are limited. Corridors show signs of wear, and while the building was warm and odour-free, some visitors found it overly heated.

Staff were generally well-regarded, with residents describing them as kind and respectful. However, there were concerns about personal care delays, especially for bedbound residents. Family members noted that care plans weren't always followed regarding shower frequency.

Nurses are always available, and external support is brought in when needed. Dementia training is ongoing, and a specialist visits monthly. Wellbeing services like nail care and massages are offered.

Residents were encouraged to take part in games and music sessions, and individual engagement for those in their rooms had improved. Visiting is flexible, and family events help promote connection.

Dining was structured and positive in Bradwell and Dove Lane, with attentive staff and pleasant setups. Memory Lane was less formal, and some residents appeared to need more help than was available. Meals were well received, with noticeable improvements since the new chef started. Menus and dietary needs were clearly displayed, and snacks and drinks were readily available.

Bed baths were more common than showers, and some families raised concerns about toileting and hoist use in smaller rooms.

Rooms reflected personal tastes but needed decorating. The lack of interpreter provision for non-English speakers, especially during GP visits, was noted as a key area for improvement.

5 Methodology

The visit was prearranged in respect of timing and an overview explanation of purpose was also provided.

The Authorised Representatives (ARs) arrived at 9.30am and actively engaged with residents between 10:00am and 4:30pm

On arrival the AR(s) introduced themselves to the Manager and the details of the visit were discussed and agreed. The ARs checked with the provider whether any individuals should not be approached or were unable to give informed consent. The Manager provided the AR with a thorough tour of the Home and introduced them to staff and residents along the way. The AR was subsequently afforded access to all parts of the Home for the duration of the visit.

The AR used a semi-structured conversation approach in meeting residents on a one-to-one basis, mainly in the communal areas. The checklist of conversation topics was based on the pre-agreed themes for the Care Home visits. Additionally, the AR spent time observing routine activity and the provision of lunch. The AR recorded the conversations and observations via hand-written notes.

Residents were approached and asked if they would be willing to discuss their experiences. It was made clear to residents that they could withdraw from the conversation at any time.

A total of 7 residents and family members took part in these conversations.

In respect of demographics: -

Three of the residents we spoke to were male and four were female with ages ranging from 80 to 93 years of age.

There was a wide range of reason and method of admission for the residents stay at the home from planned admission for those not managing well at home, to hospital admission and dementia care.

Length of stay varied from a few months to over seven years for the residents and family members that we engaged with.

At the end of the visit, the Manager in charge was verbally briefed on the overall outcome of the visit.

6 Summary of findings

6.1 Overview

The Home is registered to provide care for a maximum 64 of residents and at the time of our visit there were 52 residents at the home, 37 of whom had a diagnosis of Dementia.

At the time of our visit there was not a registered manager at the care home, the Operations Manager had been acting in a caretaker role for several months.

The home is situated at the end of a quiet cul-de-sac and is a purpose-built single-story building of brick construction with gardens to three sides and internal court yards giving garden view to the majority of bedrooms.

6.2 Premises

The layout is simple, based around a square, within a square (two courtyard gardens are within the outer perimeter) making the floor plan fairly easy to follow, with access codes to two distinct areas within the main home. Dove Lane (mild/moderate dementia) leads to Acorn/Memory Lane, which is the main Dementia area of the home, both areas are accessed from either main reception or Bradwell which is the general residential/nursing/mild dementia area of the home and is situated at the front of the home off the main reception.

The home is single story which means access to all areas is very easy for staff and for residents with no mobility issues. For people with limited mobility some bedrooms are small and hoists in these rooms are difficult to manoeuvre. This limits the time that staff spend when interacting whilst providing personal care to residents.

Due to the age of the building, there are no ensuite shower facilities. However, there are three shower rooms plus three shared bathroom facilities available to residents, and all bedrooms have their own toilet.

There were mixed reviews on bedrooms depending on mobility. Residents who were mobile and in larger rooms said they were happy and content. Residents in smaller rooms and bedbound were less content as the use of hoists was restricted and/ or difficult to manage in the space limiting the time they were out of bed.

Residents told us they like the views into green space from their bedrooms, seeing nature even if bedbound. They enjoyed the interaction when staff would wave and smile from outside, such as the maintenance teams passing while watering plants and cleaning windows (observed during the visit).

There was little Dementia friendly décor or signage observed, even in the dedicated Dementia area of the home, Memory Lane, which has been recently decorated. There are a few wall-mounted puzzle games, but all doors are plain white, and room names are very small. There is no significant individualisation outside any room. Rooms themselves had been personalised. The corridors are

painted in a pale but cheerful colour but the lounge/dining room, even though over-looking the large courtyard, looks tired. The corridors are carpeted and this, as much as it keeps noise levels low, is not particularly inviting. There was no evidence, on Memory Lane or Dove Lane, of resident's personal memory books. One family member told us that their person's book had been made but it was kept in the Managers office.

The home seemed clean and odour free throughout the visit with no obvious hazards to residents, visitors, or staff.

Residents all seemed happy with the temperature; it was a dull but warm day with windows open, yet the heating was on full. The heating was turned high enough to warm cake on the windowsill over a radiator. No residents complained to us, although a few visitors said they thought it was pretty warm. In fairness, the visitors were moving about, and residents are a lot less mobile.

The corridors in most of the home are showing signs of wear and tear, this was noted after our visit in January 2024 and no obvious update has been made.

6.3 Staff interaction and quality of care

Staff were generally well liked by residents and some of the comments received regarding staff were:

'Staff engage well with my [loved one] and respect [their] needs'

'Staff just come in and carry on, they only bother to knock if the door is shut'

'Staff do know food preference, but [resident] likes most things'

When we asked about residents getting up at preferred times we had mixed responses:

'It's 11.30 now, my person should be up washed and dress so they are ready and can go to the dining room for lunch, but because they don't have enough staff they are running late, if they have to stay in bed all day again that is not good enough.'

'I can do most things myself once I am out of bed, just need help getting up, sometimes have to wait a long time.'

'I can do pretty much what I want in the mornings really'

Bedbound residents' feel their personal care could be better; some family members told us that their loved ones did not have regular showers/baths. We were told it was over a week in some cases, even though these people's care plans suggested they should have a shower 2/3 times a week.

Family members of residents did believe their loved ones are safe and residents themselves repeated this sentiment. When asked if staff treated residents with respect and dignity most responses were positive, some of the comments we received were:

'They are very helpful'

'Could do with more people, they are all so very busy all the time'

'Most of the staff are very nice, they work their socks off'

'Staff are absolutely superb, get my sense of humour'

'They all have slightly different standards and could definitely do with a few more, but no complaints'

Family members were aware of, and felt involved in creating and updating, loved one's care plans. The Care Home uses an online system to record and store all resident information. Some families, we found, were not aware that they could ask any staff member to see the care plans or ask for changes to be made during visits, or when they called in for updates.

There are always nurses on shift; three during the day and two at night. For any other specialist needs or treatment, the home would follow standard procedures to bring in help from other agencies.

There is a permanent hair salon at the care home and although the hairdresser was on annual leave during our visit, the activity staff offer nail painting and hand massages as part of their wellbeing chats to those who would like it.

There is ongoing training for staff and, as there are a high number of residents with dementia, dementia training is given to all staff. Barchester Homes has a Dementia Specialist that is available to the home when needed but otherwise they visit the home once a month.

6.4 Social engagement and activities

There has been a short period of time without a dedicated activity person. However, a new person had been in place for two weeks when we visited and residents and family members said they were very pleased with the changes and the attention to detail of the new staff member.:

In the main lounge, residents were encouraged to join in the activities. They were asked their opinion and chose the music and games to be played. There is a new activity schedule that is on display and given to residents/family members. As this is quite new, not all residents are clear yet about what they can join and when. We were told they didn't mind as it was still a new schedule. We had permission from one of the residents, who is an accomplished musician and plays the piano for the church services, to photograph her and her husband enjoying an afternoon of music.

Time was being given to those in their rooms to find out their likes and dislikes, to get to know them, and to play their preferred board games or card games with them.

Visiting times are not restricted and the home welcomes visitors at any time. If it is in a resident's best interests, visitors are welcomed at mealtimes when, for a small cost, they can share a meal with their loved one.

There are resident and family meetings and also family events: fun days, parties, BBQs to encourage wellbeing and interaction between residents and families.

6.5 Dining Experience

There are three dining rooms at the care home, the largest (pictured) is on Bradwell, the general residential/nursing, with a smaller one on Dove Lane. Memory Lane, the dementia area, has a lounge/diner. In Bradwell, tables were laid with linen, cutlery, glasses, and a menu. There were spaces left for wheelchairs at some tables.

Seven residents were in wheelchairs, one using a walker and two were independently mobile. Residents chose their seating, and staff asked them to choose their meals. All residents were given large 'bibs' before eating although it was not clear to us whether this was necessary in all cases. There was a nurse and two care staff in the dining room. We noted that one of the care staff was very observant and it was clear she knew the residents well. If not for this staff member, there were a few residents who would not have managed as well during that meal. Music was played once residents had made their menu choices.

A similar pattern was followed in the smaller dining room on Dove Lane with a total of nine residents, most of whom did not require assistant to eat. There were staff on hand for those who did require assistance with their meals.

Memory Lane is less formal with no pre-set tables. If residents wish to eat at tables, places are set for them. Staff deliver people's chosen meals to them where they have chosen to sit. A few residents ate in the lounge attached to the dining room and several residents were eating in their rooms. There were not many staff visible to provide support to residents, and we observed a few residents who appeared to need more help than was given.

Residents were happy with the food and told us that it had improved since a new chef had started recently.

The menu is on the dining tables in both Bradwell and Dove Lane and also on display in the main reception area for visitors and family members to see.

Some residents' dietary requirements are clearly noted in their rooms; this is more evident in the rooms of bedbound residents. People eating in their rooms had their meals delivered after the main dining rooms. Meal service began at 12.30 and most residents had been served their meals by 1pm.

At main reception there is tea, coffee, and cake available all day for visitors. For residents, morning and afternoon tea, coffee, and snacks are taken around. There are goods baked onsite offered alongside fresh fruit. The lounges have jugs of juice readily available for residents.

6.6 Choice

Residents told us they felt they had a little flexibility around breakfast times but not a lot. We were told by a few residents that lunch was more flexible, if they were not hungry then their meal could be put aside for them to have a little later in the day. Most people we spoke to had not experienced this this option.

When we asked about bathing and oral health, most of the residents and family members said that 'bed baths' were given more often than showers and that baths were rarely offered. One family member told us that their resident's care plan stated a shower should be given every two or three days but, this had not happened for a week. The family said they did not feet this was acceptable and that it happened often to their bedbound relative. Other family members said they found it difficult when their bed bound loved ones were expected to have bowel movements in situ, even when they had requested to be moved to the bathroom or a commode, because staff found it difficult to manoeuvre the hoists in small spaces.

Individual rooms had been decorated to each resident's taste, but many were showing signs of age, the décor had not been updated, and there had not been a refresh of the paintwork in some time.

We were told by the management team at our introduction meeting that the home has not had a requirement for interpreters, even though they have residents whose first language is not English. We would remind the provider that this is not acceptable for GP visits, or for situations where capacity needs to be assessed or where consent needs to be gained.

7 Recommendations

Recommendations outstanding from the 2024 visit –
Premises

- *Ensure that the planned programme of works includes and prioritises the general maintenance, such as working showers, that have the greatest impact on residents. Including residents, or the Resident Ambassador, in the development of the work programme will create a feeling of ownership and belonging by residents.*

- *Explore the possibility of, if it is not already, including reflooring high traffic areas such as corridors with materials that are easier to clean.*

Staff interaction and quality of care.

- *We suggest that it might be useful for both staff and residents if the CNWL Incontinence team were asked to come in and offer staff some refresher training on the correct use of continence products. It may also be helpful for residents to receive some education around these products as this may change their perception that they are being rationed.* ***No evidence this has been actioned during resident conversations 2025.***

- *The management team should consider spending some time at the Home during the night shift to observe and support night staff. This may lead to uncovering training needs or opportunities that may otherwise be overlooked****. No evidence this has been actioned during resident conversations 2025.***

Dining experience

- *More residents eating in the dining rooms would have an added benefit of meals being delivered more quickly and remaining hot. While it may take more staff time to transport people, the majority would be freed up to continue with other tasks rather than attending individual rooms to deliver food and assist with eating where necessary.* ***On the day of our visit Fifty percent of residents still ate in their rooms even though there was an improvement in numbers in the dining rooms, 2025.***

- *The dignified dining toolkit: https://www.ageuk.org.uk/bp-assets/contentassets/2d42698f64294f3993e75b378eb3292a/dignified-dining-toolkit-v6.pdf and Creating a positive dining experience: creating-a-positive-dining-experience-for-care-home-residents.pdf This still applies 2025.*

Social engagement and activities

- *As with the mealtimes, many residents would like to leave their rooms more but need assistance or equipment to enable this.*

We have suggested to all Care Homes that they look at developing a Biography service. This could be carried out by a local school or parish volunteers. Residents can record memories of their life or may wish to write letters to specific people in their family. Photos could be included, the biography can be as short or long as they want, this can be incorporated into existing reminiscence therapy sessions. ***If this has been actioned – there was no evidence of this in the care home 2025.***

If help is required with activities or support for residents with dementia, it may be useful to contact a local memory club: https://www.healthwatchmiltonkeynes.co.uk/advice-and-information/2019-07-08/dementia-memory-clubs-and-support-groups

Additional recommendations 2025

- Consider looking at the resident/staff ratios and investing in additional staff, having spoken with family and residents and spending time at the home, with the resident mix at Ashby house additional staff would allow the team time to give residents a little time and conversation whilst interacting, with less need to 'rush' to their next task.
- During our conversation we were advised there had been no need for interpreters at the home. However, as there are residents whose first language is not English, it is part of your 'duty of care' to ensure residents have help particularly during medical exams. These should be provided by the GP practice if a notice is given when making the appointments.
- Consider ways of improving the ratio of shower/bathing facilities at the care home, at the moment 52 residents using 2 showers and 3 bathrooms is causing problems, whether this is lack of staff because of resident immobility is not entirely clear but it would be far more difficult if the home was at full capacity of 64 residents 3 showers + 3 bathrooms.

7.1 Examples of Best Practice - 2025

Your New Activity person is introducing herself to residents, spending one to one time with as many as possible, getting to know the residents, asking what they want, changing activities to what her audience wants. She is very well liked by many for just two weeks in place at the time of our visit.

8 Service provider response

We have received a response from the Operations Manager of Ashby House who has not responded to the recommendations made in this report.

We will follow up on the actions that are taken against the recommendations once the new General Manager has had time to settle in to the role.

However, a kind response was received to the visit.

Please see attached the enter and View response, Ashby has a new General Manager now who I am still supporting, I have cc into this reply.
May I take the opportunity to thank you for carrying out the visit in kindly and dignified manner
KR
Julie

Julie Dobson
Operations Manager