Ashgables House Limited

Ashgables House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service
Ashgables House is a residential care home providing accommodation and personal care for up to 26 people living with diagnoses including mental, physical health and learning disability needs. At the time of this inspection 20 people were living at the service. The service had three units, one unit was for male service users only and the other two units were of mixed occupancy.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. CQC placed a condition on the providers registration following the inspection in January 2021. This required the provider to review how they met or intended to change practice in order to meet the needs of service users with a learning disability and/or Autism taking into account current guidance and best practice.

Right support:
• People were not receiving the support they needed or wanted. People's right to access and be involved in their community was dictated by poor levels of staffing.
• There was a lack of meaningful opportunities provided to people and the focus was not on promoting and developing people's skills.
• Medicines were not being safely managed.
• At the time of this inspection the service was working on their minimum safe staffing levels. This was described to us as their 'pandemic staffing level' despite not having a current outbreak.

Right care:
• The interim manager told us they were trying to achieve this by going through the care plans but was aware it still needed to be improved. Care practices continued not to promote people's dignity at all times. This was evident in the written terminology staff used, the way preferences were not always followed and how some staff approached people.
• People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.
• People continued to not be appropriately protected against risks and the potential harm of abuse. Some identified risks and the actions to keep people safe were not being followed at the time of this inspection. We raised safeguarding's in respect of two people following this inspection due to our concerns about their immediate safety.
• Although some steps had been taken to improve the management of infection prevention control in the

home there were still areas of the service that were unclean, and a lack of staff were available to maintain cleanliness.

Right culture:
• The culture continued to impact negatively on people's experiences. The divided staff team and low staffing levels meant people's emotional needs and well-being was not always a priority. Although some improvements had happened, the focus of this had not been well directed or led to manage people's immediate safety.
• The leadership and governance of the service had not addressed areas that required immediate attention and improvement. This included risks to people and the management of these, medicine management, staff recruitment and the negative culture that had remained.
• The majority of staff spoke negatively about what it was like to work at the service and described a bullying culture that had been allowed to develop.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 9 April 2021) and there were multiple breaches of regulation.

Following the last inspection, we served a condition on the providers registration to submit a monthly action plan of improvements they were undertaking in the service. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

This service has been in Special Measures since the inspection in January 2021. During this inspection the provider has not demonstrated that improvements have been made. The service remains rated as inadequate overall and is still in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

During the inspection in January 2021 we were made aware of a specific incident in which a person using the service was taken to hospital following a fall. This person was found with unrelated significant indicators of neglect and has since sadly died of Covid-19. This incident is currently being investigated separately to this inspection under CQC's specific incident protocols.

We have found evidence that the provider needs to make improvements. Please see the full report for details.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashgables House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering

what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Following this inspection, a letter of intent was sent to the provider to request information on how they would take action in response to some immediate concerns. The provider response did not offer enough assurances, so we wrote to the provider a second time. Following this response, we took urgent action to serve a Notice of Decision and stop any new admission to the service without the prior approval of CQC.

We are currently considering what further enforcement action will be taken. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ashgables House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was untaken by two inspectors, an assistant inspector and a specialist nurse.

Service and service type
Ashgables is a 'care home'. 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.

The service did not have a manager registered with the Care Quality Commission at the time of this inspection. This means the provider was solely legally responsible for how the service was run and for the quality and safety of the care provided at this time

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and two relatives about their experience of the care provided. We spoke with twelve members of staff including the interim manager and newly appointed manager.

We reviewed a range of records. This included eleven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with three professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection on 14 and 21 January 2021, we found the service was not equipped to prevent the spread of infection adequately. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection although some improvements had been made, further work was needed to fully address this. The provider remained in breach for a second consecutive time.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We observed that some communal bathrooms had toiletries around the bath and window sills that were not removed following each person's use of these facilities. This increased the risk of cross infection.
- Although maintenance work was in progress there were still areas of the home that prevented effective cleaning due to the poor décor condition. For example, we observed old and broken flooring in one toilet and some shower curtains did not look clean. The provider told us that there was a maintenance plan in place, however some work plans had been delayed due to global pressures limiting availability to materials.
- Across all units people were using commodes but there was no record of these being cleaned.
- The provider had failed to recruit cleaning staff to the service. This was undertaken by care staff whilst they were allocated to support people and did not effectively allow time to be dedicated to cleaning.
- There were cleaning schedules in place, these included 2 hourly touch point cleaning as well as a general cleaning regime.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

The failure to take adequate precautions to prevent and control the spread of infection was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection on 14 and 21 January 2021, we found the service had failed to provide safe care and

treatment to people by mitigating risks and learning from previous incidents. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had failed to take the necessary action and remained in breach a second time.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● People continued to not be appropriately protected against risks and potential harm. Some identified risks and the actions to keep people safe were not being followed at the time of this inspection.

● We were informed at the start of the inspection that no one was at risk of choking however this was incorrect. We found a risk assessment for one person which stated they were at high risk of choking, aspiration and deterioration of swallowing. This person had been assessed by the Speech and language team in January 2021 and again in March 2021 and deemed necessary to receive a specialised softened diet and thickened fluids to prevent choking. We observed this person was given an incorrect diet by staff and a review of their care plan showed they had received high risk foods since they returned to the service in April 2021. The management told us they had stopped giving this person the assessed diet because they had received a verbal handover, from another healthcare professional, that this person was eating well and no longer needed to follow the SALT recommended guidelines. However, there was no documentation to support this and the verbal handover had not been recorded. There was no evidence that this had been based on any clinical assessment or review by a professional. This person therefore had been put at increased risk of harm. Following our inspection, the interim manager requested an emergency SALT assessment to review this person.

● The provider informed us an appropriate assessment by a SALT had been completed following our inspection and professional guidance was being followed.

● One person's care plan recorded they had a medical condition that required them to not drink excessive amounts or it would have a detrimental effect and potentially require them to be hospitalised. They were required to have their drinking monitored and recorded daily. We were informed by staff this was not being recorded but that they would try and observe what was drunk. This was not effective in order to meet this person's needs given the low staffing levels and that they were not able to observe this person at all times.

● One person in the service displayed highly sexualised aggressive behaviours towards female staff and physical and verbal aggression towards other people living at Ashgables on a daily basis. These behaviours had recently escalated however there was no additional guidance for staff on how to manage this and staff told us the current guidance was not effective. The management team told us they were aware this was an area that needed development however, they had been focusing on other areas of the service. This meant that people and staff were left vulnerable and at increased risk of assault.

● Staff spoke emotionally about how they were frightened when supporting this person and felt unable to safely manage their behaviour needs. One staff had refused to work with this person. Staff commented, "Since I have worked at Ashgables there has been nothing official put in place or writing to help us know how to manage this sort of behaviour. When the sexual behaviour comes too much towards female staff they go to the office where they get told that the person can't be that bad" and "It's extremely difficult to manage this sexual behaviour for all of us, it is literally mentally draining, upsetting and is almost impossible to work safely with this resident, and after 12 hours shift, female staff are nearly in tears."

● Another staff told us, "I personally do not feel safe and confident in this situation as there has been multiple times where I have been touched inappropriately. When I go into work, I am very anxious and there has been times that I have been working with this service user and I have had panic attacks due to being harassed. This has been reported to the office, but you never get called in to talk about this." The provider had failed to ensure this person received adequate support and that people around them were kept safe.

● Episodes of aggression were not always reported using incident forms or appropriate monitoring tools, instead these incidents were often recorded in the daily notes. This meant that when incident reports were analysed for trends, they did not reflect and accurate picture of incidents in the service.

The failure to provide safe care and treatment to people by mitigating risks and learning from previous incidents was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to the previous concerns around people's skin integrity, staff were now regularly monitoring everyone for any changes to their skin. These would then be recorded and where necessary external professionals involved.
● Incidents and accidents were recorded in a folder with space available to record actions taken and shared with staff. When care plans and risk assessments were updated the manager was able to check to ensure all staff had read it on the electronic system.
● There were a number of checks in place to ensure the environment remained safe, these included fire checks, gas safety checks and legionella checks.

At our last inspection on 14 and 21 January 2021, we found the service had failed to maintain sufficient numbers of staff and was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection staffing levels continued to impact the service provided and the provider remains in breach a second consecutive time.

Staffing and recruitment
● At the time of this inspection the service was working on their minimum safe staffing levels. This was described to us as their 'pandemic staffing level' despite not having a current outbreak. The interim manager said they had struggled to recruit and had now gone to a recruitment agency to help.
● As well as working on minimum staffing levels the care staff were expected and responsible for cleaning the service during their shifts. This was not practical or effective and resulted in staff compromising the care they provided to people. One staff told us, "We are short staffed, doing the cleaning as well and we don't have enough time to spend with people. We meet their physical needs but not their emotional needs. Staff don't want to come here. I raised this problem that there's not enough time."
● All staff we spoke with told us the service was short staffed and this was having a negative effect on the people they supported, and staff were clearly at breaking point. Comments included, "The shortage of staff is affecting staff morale, most of the time staff are being overworked and they don't have time to spend with residents" and "We are struggling, some of the residents need more staff and it's not enough to just have three staff." One staff told us, "We do not have enough time and staff to support people safely. We do not have enough staff to help residents, we are expected to clean every two hours, fill out numerous forms, assist with personal care and do things to keep people occupied as many of them become bored."
● The layout of the service had not been considered in determining adequate staffing levels. There were three units over two separate buildings, and these were over two floors. Unit one and two was very spread out over many adjoined corridors which made it hard to locate staff quickly or allow for good visibility over people.
● Another person required 2:1 staffing for activities, their care plan advised that they should be offered regular activities to reduce incidents of aggressive behaviour towards others, however staffing levels were not sufficient for this to be carried out.
● Staffing levels were not always sufficient to ensure people and staff were safe. One person displayed sexually aggressive behaviour towards female staff both verbally and physically. The service had not supplied any additional staff to manage this risk. We saw one person's care plan stated a male staff member should help them. This person's need was not being met as the service was unable to have a male on every shift at this time

The failure to maintain sufficient numbers of suitable staff was a continued breach of Regulation 18 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 14 and 21 January 2021, we found the service had failed to demonstrate that appropriate pre-employment checks had been completed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had made the necessary improvements and was no longer in breach of this Regulation.

● Improvements had been made to ensuring the required information was recorded when a staff member was employed. This ensured that people were supported by staff with the appropriate experience and character.

At our last inspection on 14 and 21 January 2021, we found the service was not managing medicines safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection medicines had continued to not be safely managed and the provider remained in breach.

Using medicines safely
● Medicines were not being safely managed.
● Pain monitoring tools were not being used to support people who were unable to verbally communicate pain. The use of pain monitoring for people with difficulty communicating is necessary to ensure that their pain level is being assessed regularly and responded to appropriately.
● A daily record of medicines was checked on units one and two during day and night shifts and on unit three at night if there was a senior on duty. We saw however there were gaps in this checking, and this was not done on a regular basis to ensure medicines were accounted for.
● Two people were prescribed antibiotics. One person received this daily and the other person three times a day. We saw that the person who was prescribed their medicine three times a day had not received any of their antibiotics on the previous day. The staff on shift during the inspection had noted this and contacted the GP, but it had not been picked up on any of the three occasions on the previous day. This was raised with the management team.
● Information about people's medicines was not always fully recorded to ensure staff had appropriate guidance to follow. We saw staff had recorded some handwritten medicine entries which were illegible to read. We saw five people had instructions recorded for medicines to take as required (PRN) however, these medicines had not been prescribed to people. This had not been picked up in audits or checks by staff. It appeared these may have been old PRN medicines that should have been removed from people's records but had been missed. We left this with the management team to address.
● Most people in the service were prescribed either nervous system depressants, antipsychotics or sleeping tablets. There were no behavioural management plans with the PRN instructions, to suggest support methods that were firstly appropriate before administering medicine to sedate and calm someone. We saw that these medicines were being administered on a regular basis without review of the effectiveness.
● We saw that topical medicines administered to people were frequently unsigned and did not all have clear instructions or body maps to support staff in the administration. This meant agency staff who did not know people well would struggle to appropriately administer people's medicines.
● One person was noted within their pharmacy sheets to have a pacemaker. The care plan contained no instructions regarding its specific provision. When asked, the management team reported they had been unaware this person had one. There was nothing in place to safely manage this risk and keep this person safe.
● People who were diabetic had a lack of information recorded around safe parameters for their blood glucose levels. There was no written advice for staff on how to recognise if a person was entering a hyper or

hypo situation in order to take effective action. The Capillary blood glucose testing kits should be used per person however, in one building it was shared between three people. The staff told us they undertook the test when necessary but did not know how to correctly use it. This meant an incorrect reading could be taken and leave a person at significant risk of not receiving the required treatment in a timely manner.

The failure to safely manage medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received training in medicines and their competency had been checked and recorded.
- People had a medicine record in place with a photograph attached.
- We saw the process of disposing of medicines was undertaken correctly and recorded.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from abuse from other people living in the home. During our inspection, we saw that one person made frequent threats of violence to other people living in the home and on occasions was physically aggressive to others.
- We saw that one person had received 33 incidents of verbal aggression and one incident of physical aggression in a two-month period. There was no risk assessment or management strategy for this person's risk of abuse and there was no evidence that the effect on their wellbeing had been assessed.
- In April 2021 one person living at the service had been physically assaulted by another person. We saw that this incident had not been reported to the adults safeguarding team to ensure other professionals were involved in maintaining this person's safety.

We raised safeguarding's in respect of two people following this inspection due to our concerns about their immediate safety.

The failure to safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us they would raise concerns to the manager if they suspected or witnessed abuse to anyone in the service. One staff said, "I have had safeguarding training and would raise anything. The office normally deal with safeguarding, so we report to them. I don't know if we can go straight to the safeguarding team."
- One person told us they felt safe at the service commenting, "I am happy here, I feel safe." Another person told us they were not happy at Ashgables and "hated it" but didn't offer further explanation. One relative told us, "I do feel [relative] is safe, no concerns."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection on 14 and 21 January 2021, we found the service was not always working within the principles of the Mental Capacity Act 2005 (MCA). This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection although some improvements had been made, further work was needed to meet this breach.

Ensuring consent to care and treatment in line with law and guidance
The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Improvements had been made to the detail on people's assessments, however some continued to need further work to demonstrate if there was anyone with Lasting power of Attorney in place (LPA) and who had been involved in the decision-making process.
- We saw that one person had restrictive interventions regarding dietary choices, however there was no evidence of a mental capacity assessment and best interest decision for this intervention.
- We saw that work was in progress to review people's capacity assessments and make any required DoLS applications.

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

At our last inspection on 14 and 21 January 2021, we found that there had been a failure to ensure staff were suitably skilled and competent. At this inspection we found improvements had been made and the provider was no longer in breach of this part of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Since the last inspection staff had undertaken further training to develop their skills to meet the needs of people living at the service. The interim manager told us this included, stoma bag care and communications training. Values and attitudes training was booked, and positive behaviour support training would be delivered when the interim manager resumed their normal role.
● Staff told us their induction had been a useful insight into the service.
● Supervisions were now being undertaken on a more regular basis and a contact log had been developed to record any discussion points prior to the supervision taking place. The interim manager said they wanted to plan more observational supervisions to take place and for these to be documented.

Supporting people to eat and drink enough to maintain a balanced diet
● People's preferences around food were not always met. For example, we saw that people had drinks however, one person told us, they had not chosen their drink and didn't know what it was, until they tried it.
● We spoke with staff about people's dietary requirements. They were able to identify people who had diabetes, but no other dietary requirements. One person said, "We could do with a bit more diabetic variety food; I have asked the office, but they say there isn't the money available." We were informed that one person was sick if given curry or chilli to eat. We looked in their care plan, but this had not been recorded or followed up on and not all staff were aware.
● People were not reminded of what the food was when it was placed in front of them. There was no formal method used to gain feedback about the food. Staff told us they asked people if they liked it, but this was not recorded anywhere or followed up.
● We observed the lunchtime experience for people which was a positive atmosphere. People appeared happy, talking to each other and staff sharing jokes and laughing. Food arrived promptly and people were not rushed and ate at their own pace.
● The day's menu was written on a white board in each of the two dining rooms. People said that they had a choice at breakfast of cereals and toast and that sometimes they had croissants or muffins. One person had chosen to eat outside, and staff supported this by taking their food out to them and ensuring it was covered.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had assessments in place which considered their physical and emotional support needs.
● We saw one person who returned from respite care did not have an adequate reassessment completed prior to their return. This was raised with the management team to follow up.
● A care plan was developed to record people's needs and how these were to be met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health needs were monitored, and we saw examples where health or social care professionals had been contacted and involved in people's care. People said staff listened to them and took action. For example, one person complained of stomach pain, and was supported to see their GP and was prescribed medicine.
● Work had been undertaken to increase staff knowledge in supporting people who often refused personal care. One staff told us, "If the refusal came all of a sudden, I would try to identify what triggered it, that's why calling the GP helps to see if it is a physical trigger, like an infection. I would take into consideration all possible causes and seek advice in how to manage it."
● Health and social care professionals who worked with the service gave positive feedback including, "I feel the staff are very knowledgeable of people and I am appreciative of their input. In my experience staff have

been quick to contact professionals if there are concerns regarding a resident" and "Every member of staff that has been on shift when I've been visiting have been very helpful when I've needed any extra information on a person."

Adapting service, design, decoration to meet people's needs

- People were able to personalise their rooms with their own furniture and other personal items. This supported people to live in a homely, more familiar environment.
- Access to outside spaces were encouraged and we saw doors were all open and people sat outside enjoying the warmer weather.
- The service was in the process of redecorating bathrooms and communal areas to ensure the environment was pleasant and safe for people to use.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

At our last inspection on 14 and 21 January 2021, we found that there had been a failure to ensure people were treated with a dignified approach. At this inspection we found that these concerns had continued, and the provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for a second time.

● During our inspection we saw that staff did not always use respectful written terminology in daily records. We saw examples of a person's behaviour being called 'rude' by staff without any further information on what this meant. Other personal care entries for people were inappropriate in the language used. The manager told us they were disappointed by this as had worked hard with staff about using appropriate content and that this should have been identified by the senior staff checks. One member of staff referred to 'commoding' when supporting people to use the commode. This showed a lack of dignity and respect when talking and writing about people.
● Staff told us they felt some staff did not treat people with respect. Examples of this given were when people were approached about receiving personal care in front of others, the way people were spoken too by staff in terms of tone of voice and attitude and the words used. One staff told us, "In my opinion some of my colleagues are not caring and respectful towards our residents. I've challenged that with the office several times and I have been assured by the management and the area manager that they are dealing with those members of staff."
● Another staff commented, "The way some staff are speaking with people is like arguing. Some residents feel intimidated or frightened by certain staff because of the way they speak to them. Some feel that some staff are talking down to them. Others don't what to upset certain staff because they will tell them off so they would rather not bother so they won't cause any problems." We have raised this with the manager to address and ensure that people are being treated appropriately.
● The division between the staff team had continued to negatively impact on the provision of care to people. One staff told us, "Unfortunately, there is not a lot I enjoy about working in this home. I love that I can help the residents and somehow make a difference for them, however sometimes I cannot do this when the staff knock others confidence and make you feel like you are not doing a good job." Despite the management team being aware of these concerns and taking some action, this had been continuing for a year.

● We saw staff had raised in their supervision that some staff were not speaking in English in front of people who use the service, which may have been uncomfortable or confusing for people. Management told us this had been raised with staff individually since these supervisions, they told us staff had not raised this as an issue again.

The failure to ensure people were treated in a dignified approach was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Some people in the service would frequently refuse personal care and staff were able to explain how they supported people around this, "I explain what I am doing and why personal care is important, I get another member of staff to help encourage them, if this then doesn't work I ask what they would like to do and then try later in the day" and "Its' pretty difficult, we have one person and I sit and talk about why its best and what would happen if they didn't. After you take time and be calm and consistent, they tend to say go on then."
● We saw that people appeared quite comfortable around staff and happy to approach them if needed. One staff said, "I enjoy working with the residents maybe because I have known them for many years, and I feel that I can try to help them with their daily lives as best as I can."
● People told us the staff were caring towards them and kind. One relative said, "The staff in general are considerate to [relative's] needs. I can say that they feel happy and settled at present."
● Health and social care professionals told us the care interactions they had witnessed had been respectful commenting, "The staff appear to work in a person-centred way and respect people's differences" and "Whenever I visit Ashgables I'm always met by friendly, upbeat staff and the service users seem happy and have a good relationship with staff."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was not inspected. The last rating in October 2018 was rated as Good. At this inspection this key question has now deteriorated to Requires improvement: This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We did not observe any activities taking place during the inspection. There was an activities hut which had arts and crafts available however, the hut was only open when the activities co-ordinator was there, and not needed to work as an extra care member of staff. It was locked throughout the inspection, as the activities co-ordinator was working as a carer. Staff told us the activity staff were frequently taken off activities and put 'on the floor' and used as a carer, which negatively impacted people's opportunities to improve wellbeing.
- The provision of activities for people were limited. The weekly activity timetable reflected this showing four out of seven days had no planned activities. On two of the three days with activities scheduled, activities were only for one person per day, on the third day, there were activities planned for two people. Staff told us they did not put more activities on the timetable because they didn't want to let people down and disappoint them when they couldn't go ahead because of being short staffed.
- Staff did not always recognise what a meaningful activity was. For example, activities were referred to as including, smoking, going to the shop to get 'snacks and fags' and sleeping. One person told us "I play bingo, colouring, sometimes go out for a meal, I smoke too, not much else to do."
- The activity staff had recognised people needed more to engage them and some successful activities had been enjoyed since lockdown easing including, shopping, trip to a wildlife park, church and a pub meal, however this was infrequent. Staff explained that the services' vehicles were prioritised for people's appointments, and this impacted on people's ability to go out for activities. Some people needed 2:1 staffing to go out and this could not always be facilitated when needed due to not having enough staff.
- We observed one person repeatedly asking to go to the pub and on which date they could go. Staff were unable to reassure this person that they could go and replied, "I don't know" and that they would have to speak with the manager about staffing and money. Another staff told us, "I do not think that the residents have enough to do. They don't have a range of activities that they can join in it seems to be the same week after week. At the moment the activity co-ordinator seems to be picking up more shifts on the floor meaning that there are less activities being offered to the residents and they are getting bored."

The failure to support people's autonomy, independence and involvement in their community was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We saw that improvements had been made to people's care and support plans to make them more person centred and specific to each individual. There were examples of personalised information relating to

people's preferences around their health needs and care support and what made them happy or sad.
● Care plans were now available electronically and staff were able to update and review these as care was provided. On the whole staff felt the care plans were an accurate representation of people's needs, however a few staff felt the office staff completing them did not always know or understand the residents as well as the staff working with them.
● We saw that whilst care plans had improved to be more personal, they at times lacked specific guidance for staff in undertaking practice. For example, there was a lack of physical care instructions for staff to follow in supporting people who had urinary catheters, pacemakers or needed stoma care.
● Risk assessments often did not record what the actual known risk was for each person. For example, one person's risk stated personal care but not what the exact risk was from personal care. Another person's mental health assessment stated the risk was injury, but again not details on how an injury could be caused or what kind of injury this meant.
●There was a lack of review in what methods of support had been offered and what had or had not worked. One person would tend to wear inappropriate clothing for the time of year, such as five layers of clothing in hot weather. The care plan did not have support strategies to reduce any negative effects such as offer more drinks or putting a fan in the person's room.
● We saw staff were now recording injuries to people's skin when they noted them, however these did not offer an explanation of how a person obtained these injuries or what had happened. For example, one person had 14 entries of broken skin and redness recorded but no further details. The interim manager said "We are having issues with body maps and staff understanding. Staff are typing what's happened but not updating the entries, so it looks like people have loads of ongoing injuries when they are actually old injuries." This continued to be addressed in meetings with staff.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Peoples communication needs were recorded as part of their care plan with guidance available for staff.
● The manager told us different formats depending on the needs of the individual could be provided including easy read and pictorial.

Improving care quality in response to complaints or concerns
● A system was in place to manage any concerns or complaints raised about the service.
● A pictorial complaints procedure was displayed within the home for people who needed it in this format.
● Relatives told us they felt happy to raise concerns and speak up if needed. One relative said, "I would raise anything."

End of life care and support
● People had the opportunity to discuss any end of life wishes they had for care and support treatments. We saw these recorded in their care plan.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection on 14 and 21 January 2021, we found that there had been a failure to effectively monitor and improve the service for people. At this inspection not enough action had been taken to improve the service and the provider remains in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for a second time.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the time of this inspection a registered manager was not in place. An interim manager was overseeing the service and a new manager had been recruited and would be registering shortly. One relative told us, "The frequent turnover of management has been somewhat disturbing in the past. Let's hope this situation is now rectified."
- The service was working towards an action plan and focus had been on rewriting care plans and putting in place levels of accountability and checks among the staff team. However, there were areas that had required immediate attention and improvement that were still not completed at this inspection. This included risks to people and the management of these, medicine management, staff recruitment and the negative culture that had remained.
- Not all of the concerns we identified had been picked up despite reviews taking place, which meant timely action was not taken and people had been put at increased risk of harm. This was evident for one person who was a choking risk and another person whose behaviour was causing physical and mental harm to others.
- There were some gaps in the oversight of the service and knowledge of people. For example, the management team were unable to tell us how many people resided in each unit of the building and their room members. This information was not recorded within the office and a member of staff had to walk around the building to write this down. The management team were unable to tell us who was on the most complex medicines and did not know one person had a pacemaker which required careful risk management.
- There was variations in the checking and recording by staff members. The interim manager told us, "There are some staff where there has been an improvement in recording and how they write and others I don't know if it's a cultural difference and if so, I need to support them in this." It was clear that due to not effectively managing the divisions within the staff team this was having a negative impact on driving improvements forward.

The failure to assess, monitor and improve the quality and safety of the service effectively is a continued

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

● We found that two notifications had not been made to CQC. This included two incidents of abuse. Appropriate action had not been taken to ensure people remained safe. The management team told us this had been an oversight.

The failure to notify of incidents of abuse is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture within the service continued to foster a negative working environment that impacted on the people living at Ashgables. The majority of staff spoke negatively about what it was like to work at the service with some looking for other employment.

● Staff spoke about a bullying culture that had been allowed to carry on for a significant period of time and not dealt with effectively. This had impacted some staff's mental health and staff were emotional when describing how desperate they had felt from working at Ashgables House.

● One staff told us their experiences of being bullied commenting, "Some staff are not caring and respectful to other members of staff. When I am working, I feel uncomfortable working with some members of staff, I also was bullied my first weekend. I have been to the office several times, so now I don't feel as though I can go to the office and tell them how I am feeling at work."

● Other staff commented, "We are not really a close team, it's not how it should be and we don't always work as a team", "One staff has left as they have been bullied and management will not do anything about it which is very sad", "The staff morale is not good at all, the team has a divide and those you think you can trust you can't. They will backstab you any chance that they get and rip any little thing you do wrong apart" and "Due to how things have been, I have felt so low for so long and it has impacted badly on my mental health."

● Whilst staff felt the interim manager and new manager was approachable, they gave mixed reviews on the support they received and the way the service was led. Staff told us, "It's got better, [interim manager] has tried to support us, can go to her with anything, [new manager] will come and talk to us and made us aware the door is open" and "I don't enjoy working in the home, the management are very poor and unapproachable. They just sit in the office and don't care what's happening on the floor."

● We discussed this feedback with the management team who were aware of the staff concerns. Although actions were in progress, not enough had been done in a timely way to prevent this from developing, worsening and affecting the people who used this service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● At the last inspection we reported on the fact that the management details for people to contact was incorrectly displayed on the provider's website. The manager shown had not worked at the service since June 2020. This continued to be displayed incorrectly and does not inform people who is managing the service and who they can contact.

● A complaints procedure was in place to manage concerns raised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We saw that staff meetings had taken place and events relating to the service were shared with staff.

● The interim manager had put a suggestion box in the service for staff to share their concerns with them to

be addressed but told us staff were not forthcoming. Staff we spoke with said they had lost faith in action being taken as they had not seen any changes.
● There was mixed feedback regarding the communication relatives received. One relative told us they had not been informed or had an opportunity to discuss the last inspection report, so had been unaware of the impact this had on their family member. The interim manager told us a letter had been sent to relatives following the inspection report but would resend this and include an update.

Continuous learning and improving care
● Improvements to the service were ongoing. Management staff attended fortnightly calls with CQC to discuss the action plan submitted monthly and provide a service update.
● Staff told us there had been improvements noted within the service, but further work was needed. One staff commented, "There have been changes, we check more things now and have more responsibilities."
● The interim manager told us, "At the moment the focus is on getting the care plans done, because there has been so much going on with safeguarding and a lot information that has been sent and trying to keep staff happy has been very time consuming."

Working in partnership with others
● The service had been working with a range of professionals following the last inspection in order to meet people's needs.
● Three health and care professionals gave positive feedback of their relationships with staff and the care provided.
● Information was not always clearly communicated to other agencies due to poor record keeping. For example, we saw one person's behaviour monitoring charts were not an accurate reflection of the persons behaviour, this meant their needs were not accurately communicated to external professionals who reviewed these documents in order to give appropriate support.