

Ashville Care Limited

# Ashville Care Home

## Inspection report

58 Sandmoor Garth  
Idle  
Bradford  
West Yorkshire  
BD10 8PN

Tel: 01274613442

Date of inspection visit:  
14 February 2017

Date of publication:  
28 March 2017

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Inadequate 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

Ashville Care Home provides personal care for up to 29 older people, some of who are living with dementia. There were 25 people using the service when we visited. Accommodation is provided on two floors with lift access between each floor. There are four communal areas on the ground floor which includes a large dining area.

This inspection took place on 14 February 2016 and was unannounced. At the last inspection on 12 April 2016 we rated the service as 'Requires Improvement' and identified 3 breaches of regulations relating to 'Safe care and treatment', 'Staffing' and 'Good Governance.' At this inspection we found improvements had been made to staffing levels, however we identified four breaches of regulation.

Although we found some good areas of practice during the inspection, we rated the safe domain as 'Inadequate.' This was because a number of concerns were found relating to management of risk, the premises, 'as required' medicines and prescribed creams. Some of these concerns were similar or identical to issues raised at the previous inspection, meaning we did not feel assured that they would promptly resolved.

A registered manager was in place who had been in post for several years. 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.

People and relatives we spoke with provided good feedback about the home. They said staff were kind and treated people well. They said care and support met people's individual needs.

Most people received their medicines as prescribed. However, 'as required' medicines and topical creams were not always managed in a safe or proper way.

Care records demonstrated a number of risks to people's health and safety were assessed for example in relation to skin, nutrition and moving and handling. However, there was a lack of assessments in place relating to the safe management of bed rails. We identified a number of wardrobes in people's bedrooms which were unstable and risked injury to people.

There was suitable space within the premises for people to spend time and some adaptations had been made to the premises to meet the needs of people living with dementia. However, we found a number of maintenance issues relating to the premises which required resolving to ensure people were cared for in a comfortable and well maintained environment.

People told us they felt safe in the home and comfortable in the company of staff. Safeguarding incidents were recorded and in some instances we saw records of action taken to keep people safe. However, referrals

had not always taken place to the adult protection unit and care and support plans were not always updated following incidents.

During the inspection we found there were sufficient staff available to meet people's individual needs and staffing levels had been increased since the previous inspection. However we had some concerns that staffing levels may not be sufficient during the overnight period. Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. DoLS applications had been made for a number of people living in the home. Staff respected people's choices and gained consent before delivering care and support.

People had access to a range of suitably nutritious food. This included a choice of meals and snacks throughout the day. Action was taken where people were at nutritional risk.

Staff had access to a range of training relevant to their role. Staff said they felt well supported and had regular supervision and annual appraisal.

People and relatives said staff were kind, caring and treated them with dignity and respect. This was confirmed by our observations of care and support on the day of the inspection. Staff knew people well and their individual likes and dislikes. We saw good positive relationships had developed between people and staff.

Since the last inspection care records had been transferred to an electronic care recording system. We found electronic care plans lacked detail about people's specific care and support needs. Care records were not always accurate and were not always updated when people's needs changed.

An activities co-ordinator was employed who delivered a schedule of activities to people. This was appropriate for the needs and requirements of the people who used the service.

The registered manager was 'hands on' and regularly involved in care and support within the home. People, relatives and staff we spoke with spoke positively about the way the home was led and said they felt able to raise any problems or concerns with the registered manager.

Systems to assess, monitor and improve the service were not sufficiently robust as they had not been effective in driving the required improvement since the last inspection and had not prevented the breaches in regulation that we had identified.

We found four breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Inadequate ●

The service was not safe.

We found evidence most people received their medicines as prescribed. However topical medicines and "as required" medicines were not always managed in a safe or proper way.

We found safeguarding processes had not been fully followed to ensure people were kept safe. Referrals had not always taken place to the local authority safeguarding unit.

Since the last inspection, improvements had been made to staffing levels. People and staff said there were enough staff deployed, although we still had some concerns staffing levels were not always adequate at night.

Risks to people's health and safety were assessed and risk assessments put in place. However we found risks associated with bed rails had not been assessed and a few safety related concerns on walking around the premises.

### Is the service effective?

Good ●

The service was effective.

Staff received a range of training and support relevant to their role. New staff completed the care certificate and existing staff received regular training updates. Staff received training in dementia care.

The service was compliant with the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager understood the relevant legislation and appropriate DoLS applications had been made.

People received a range of food and drink and steps were taken to boost people's nutritional intake where they were at risk of losing weight.

The service liaised with healthcare professionals to help ensure people's healthcare needs were met.

### Is the service caring?

Good 

The service was caring.

People and relatives said that staff treated people with dignity and respect. People were listened to by staff.

Staff knew people well and their individual likes and preferences.

People's end of life care needs were assessed and plans of care put in place.

### Is the service responsive?

Requires Improvement 

The service was not always responsive.

People and relatives said care needs were met and staff demonstrated a good knowledge of how to deliver the required care and support.

However care and support plans were not person centred and did not provide enough information on people's care and support needs.

A system was in place to log and respond to complaints. People were encouraged to comment on the quality of the service.

### Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Areas for improvement identified at the previous inspection had not been fully acted on. Audits and checks were undertaken but these were not fully effective in identifying and resolving issues.

People's feedback on the service was regularly sought and people's views and experiences were listened to.

People, relatives and staff spoke positively about the way the service was managed. We found a friendly and person centred atmosphere within the home.

# Ashville 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 checked 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 by notification of safeguarding concerns received about the service. This is subject to a safeguarding investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns. This inspection examined those risks as part of a full comprehensive inspection of the service, following up on the breaches of regulation identified in the last inspection in April 2016.

This inspection took place on 14 February 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

We spoke with five people who were living in the home, two relatives/friends, five care staff including day and night staff, the chef, the deputy manager and the registered manager. We also spoke with a health professional who has contact with the service.

We observed care and support and 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 looked at elements of five people's care records, staff files, medicine records and the training matrix.

# Is the service safe?

## Our findings

We found a number of safely related concerns during the inspection. Although the registered manager accepted that a number of improvements were required, some of the concerns found were similar to those identified during the previous inspection, which meant we were not fully assured they would be promptly resolved.

People we spoke with told us they received their medicines when they needed them. We observed staff administering medicines at different times throughout the day. We saw they were patient and kind with people, giving them the support they required and staying with each person until they were sure the medicine had been taken. We saw there were suitable arrangements in place which ensured medicines prescribed to be taken at a specific time were given correctly such as medicines that must be taken before food.

We looked at the medicine administration records (MARs) and found these were well completed for some but not all medicines. For example, the MARs showed medicines given on a regular basis from a dosette box were signed for and there were no gaps. However, MARs for medicines prescribed on an 'as required' basis were incomplete and there were not always protocols in place to guide staff as to when and how often to give these medicines. We also found where there were protocols in place these were not always accurate or up to date. For example, we saw a protocol for one person which stated they were prescribed a sedative on an 'as required' basis, yet the MAR showed this medicine was prescribed and given three times a day. The deputy manager confirmed this medicine had previously been prescribed 'as required' but was not anymore. We saw another two people were prescribed sedatives 'as required' on the MARs but there were no PRN protocols for either of these medicines. This meant there was a risk of inconsistent administration of these medicines

We also found discrepancies in the management and recording of topical medicines such as creams and lotions. We saw creams in two people's bedrooms which were prescribed for other people. We also found creams we saw in people's rooms were not prescribed for them when we checked the individual MARs. Where people were prescribed creams, the MARs had not been signed to show that these creams had been applied. We discussed this with the deputy manager who told us they had taken action to remove the creams from people's rooms and would be putting new systems in place to address these shortfalls.

Some people were prescribed thickening agents. There was no information with the MARs or in the care plans to show the amount of thickener to be used and no record to show the thickening agents had been given.

We found conflicting information recorded about covert (hidden) medicines. Records indicated one person received their medicines covertly. The deputy manager said this wasn't the case but told us of two other people who received their medicines covertly. However, the registered manager told us no one received their medicines covertly. They told us one person had capacity and had requested to have their medicines in a drink which had been agreed with their GP and pharmacist. They said the other person's medicines

were all dispersible and the person took them in their juice. This was not evidenced by the MAR which showed only two of the five medicines listed were dispersible. The registered manager acknowledged the care records and MARs did not reflect these decisions or show the processes that had been followed in reaching them.

We found other information kept with the MARs was incorrect or needed updating. For example, a record for one person stated they had their medicines crushed and added to their drinks. Yet the deputy manager told us this was incorrect as the person took their medicines normally. The issues identified above meant that medicines were not always managed in a safe or proper way.

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

All medicines were stored securely and the temperatures of the storage areas, including the medicines fridges, were checked to make sure they were within the recommended limits. Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and a random selection of stock and found they were correct.

People we spoke with told us they felt safe in the home and raised no concerns over the conduct of staff. Relatives and visitors also said they thought the home was a safe, friendly and supportive environment. Staff were aware of safeguarding and demonstrated they knew how to raise concerns. They said they were confident people were safe from abuse and would be happy for their relatives to live in the home. However, we found systems and processes designed to protect people from abuse were not being operated properly by the service. We looked at the safeguarding file where safeguarding reports were filed and the log showed there had been one safeguarding incident since the last inspection. This had been referred to the local authority safeguarding team and notified to the Care Quality Commission. However, our review of people's care records identified four other incidents which the registered manager confirmed had not been referred to safeguarding. These all related to incidents between people who used the service. For example, one person had been hit by another, one person had been shouting and screaming at other people causing them distress and another incident described one person pushing other people and shouting at them. Although staff had taken action to keep people safe when these incidents occurred, these incidents had not been identified as safeguarding or reported in accordance with safeguarding procedures and in some instances there was a lack of clear plan and strategy going forward to prevent a re-occurrence. For example following one incident the relevant care plans for the people involved had not been updated.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety were assessed for example around nutrition, skin and moving and handling. Risk assessment scores were calculated and where significant risk was identified plans of care were put in place. Staff demonstrated a good understanding of the risks people posed and how to effectively control them. However, risk assessment and care planning documentation was not person centred so did not always reflect the knowledge of staff. We also found a lack of bed rail risk assessments for people who had bed rails in situ. Health and Safety Executive Guidance on the safe use of bed rails requires that the risks and benefits of bed rails are considered in order to come to an informed decision over the correct plan of care and that any subsequent equipment put in place is assessed to ensure it is compatible, in working order and safe. We found free-standing wardrobes in some people's bedrooms were unstable and unsafe as they were not secured and could easily be pulled over by someone. The registered manager



told us this would be addressed straightaway.

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

At the last inspection we had concerns around staffing levels within the home. At this inspection, we found improvements had been made to staffing levels during the day with an additional staff member now on duty from 7am to 10pm. During the day, one senior and three care workers now cared for the 25 people living in the home. The registered manager also worked five days a week and helped out with care and support tasks. Ancillary staff such as an activities co-coordinator and a cook were also employed. People and relatives all said they thought there was enough staff in the home. For example, one person told us, "Enough staff, staff are always at hand if you need them for anything day or night." We spoke with day and night staff who all told us they thought there were enough staff deployed to ensure people received prompt care and support. During observations of care and support we found staff were available to attend to people's needs and able to promptly provide assistance where required. Although we found no compelling evidence that staffing levels were unsafe during the overnight period we had some concerns that they may not always be sufficient. Two care staff were on duty between 10pm and 6am. When we arrived at 5am there were two night staff on duty and six people were up in the different communal areas. Night staff told us these people were awake a lot of the night and walked around, often sitting in the communal areas. We asked how many people required two staff to assist them and were told between five and six people. This meant that when both staff were assisting these people there may not be adequate supervision of others within the home. Although a dependency tool was used to assess staffing levels within the home it did not consider specifically the night time period and the number of people who were usually awake. We asked the registered manager to review staffing levels during the overnight period.

Safe recruitment procedures were in place. We looked at three staff files. There was evidence of an application form, identity checks, disclosure and barring service checks and at least two references provided. Previous qualifications had been checked. Staff were required to complete a probationary period and had their competency and skill level continuously assessed during this period. Staff we spoke with confirmed they had been subject to the required recruitment checks. Staff rotas were carefully planned and the skill and experience level of staff was used to plan rotas to ensure shifts always had the correct mixture of experience and competence. This helped people to receive a consistent quality of care and support.

We looked around all areas of the home including bedrooms, bathrooms and communal areas. We found communal areas were brightly decorated and comfortably furnished, as were some of the bedrooms which were personalised with photographs, ornaments and pictures. However, other bedrooms we reviewed were stark in comparison with few personal effects. We also identified numerous maintenance works which needed addressing. This included minor repairs such as a broken radiator guard, missing or broken toilet roll holders, missing bed headboard, damaged light fittings, a missing toilet cistern lid and a broken toilet seat and lid. We saw some call bells were not accessible to people either because the leads were tied up or the call bell was not accessible for the bed or there was no call bell lead. We saw an en-suite facility in one person's room could not be accessed as the door was screwed shut. A staff member told us this was because the toilet was broken. We found some areas of carpet on the stairs and corridor were heavily marked and stained.

We saw daily temperature checks were recorded of the hot water in people's bedrooms, the bathrooms and toilets. The records showed since early January 2017 the temperatures recorded were all around 36°C. The last check had been carried out the day before our inspection and recorded 36.2°C for all taps. We checked the hot water with the home's temperature probe at three different sinks and although we ran the taps for

some considerable time the highest temperature recorded was 30.4°C. The registered manager told us there were problems with the water temperatures as new boilers had been installed and although the heating was working fine, there were ongoing problems with the water which they were trying to sort out.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw certificates which showed up to date checks had been carried out in relation to moving and handling equipment, gas safety, Legionella, electrical wiring and fire safety equipment. We found the fire risk assessment dated 7 January 2015 was incomplete. The registered manager told us there was an updated version but was not able to produce this document.

## Is the service effective?

### Our findings

We found staff had the right skills and knowledge to care for people. People and relatives praised staff and said they knew how to provide effective care. Staff we spoke with said training was appropriate to their role and gave them the necessary skills needed to carry out their role.

New staff were required to complete the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards. Other long standing staff had also completed the Care Certificate in 2016 to help ensure they also had the same skill and knowledge base. New staff also received a local induction to the service which provided familiarisation with the service's policies and procedures and ways of working. We spoke with a new staff member who said that they had received an appropriate level of support, training and supervision to enable them to learn how to undertake the role.

Staff received regular training updates in subjects such as dementia, medication, mental capacity Act, DoLS, safeguarding, infection control and manual handling. This was done face to face by an external training provider. We saw training was mostly up-to-date and where it had expired we saw evidence which showed training courses had been booked to take place in the near future.

Staff had also received specialist training in areas such as pressure area care and end of life care from local health professionals. A pressure area 'staff champion' had been appointed who had received specialist training and was in the process of training other staff within the service to disseminate this specialist knowledge.

Staff received four supervision meetings a year and an annual appraisal. This provided staff with the opportunity to raise any concerns or issues, for developmental needs to be addressed and performance to be assessed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

We found the registered manager had a good understanding of the principles of the MCA and DoLS and had made appropriate applications where people were being deprived of their liberty. The registered manager told us seven people had DoLS authorisations in place and said six of these had conditions in place, which had all been met. The registered manager told us DoLS applications had been made for other people which were awaiting approval.

Throughout our inspection we saw care staff explained what they were proposing to do and asked people's permission before providing support. Staff we spoke with had a good understanding of how to manage people's refusals to accept care and support and used a range of techniques to encourage people to maintain their health and hygiene. However, we found although consent was sought in practice this was not always reflected in people's care documentation. The registered manager accepted that improvements were required to the way information was recorded on the newly implemented electronic care recording system.

People spoke positively about the food provided, for example one person said, "Food is brilliant." Two cooks were employed who worked seven days a week and prepared lunch and the evening meal with care staff preparing breakfast. A two week rotating menu was in place which provided people with sufficient variety of food and a choice at each mealtime. The main meal was served at lunchtime with lighter options in the evening. At lunch on the day of the inspection there were two options; Lancashire hot pot or cottage pie followed by a sponge based dessert. The cook explained to us how the menu had recently been changed and improved to ensure people were provided with a high calorie diet. They told us food was fortified with butter and cream and people were provided with various snacks thorough the day. This included cakes, fruit, milky drinks and chocolates. This was confirmed by our observations of care and support and review of people's dietary intake over a number of days. People's individual requirements were catered for. For example, low sugar desserts were made for diabetic people living in the home.

During observations of care and support we saw people were provided with a range of meals, snacks and drinks throughout the day. People who were up early were offered breakfast and a hot drink at 6am and we saw people enjoyed having porridge, cereals and toast. Breakfast was provided throughout the morning as people got up and we saw those who had an early breakfast had a second breakfast later on. We saw staff kept track of who had eaten by filling in a chart which showed what people had had and ensured no one missed a meal. People's individual preferences were sought by showing people show plates, pictures and menus to promote choice at each mealtime.

We saw people's weight was monitored and appropriate action had been taken when people had lost weight such as fortifying meals, providing snack boxes and seeking advice from dieticians. We saw this was effective as care records showed people's weight had increased when there had previously been a loss.

People's healthcare needs were assessed and the service worked with external healthcare professionals to ensure people's needs were met. Care records provided evidence the service liaised with external health professionals including district nurses and GPs over their healthcare needs. Contact with professionals and their advice was recorded within medical notes section of the electronic care records. Although we were assured that people's healthcare needs were met by the service, advice from external health professionals was not always used to update care and support plans.

Adaptions had been made to the building to assist people living with dementia, albeit the overall environment was tired and required modernisation. For example, a range of different environments had been created including a bus stop and sensory material was on display. People could walk a route around the downstairs without meeting a dead-end and we saw this route was enjoyed by several people during the inspection. We observed care and saw people appeared calm and happy in their surroundings. The manager consulted National Institute of Health and Care Excellence (NICE) guidance on dementia and had recently completed a university course in dementia care as part of a strategy to be up-to-date on the latest and most effective care and support techniques. All staff had received training in dementia. Thought had gone into the provision of activities to help ensure they met the needs of people living with dementia. This included activities which stimulated the senses such as taste and touch.

# Is the service caring?

## Our findings

We found a positive and caring culture within the home. Overall people told us they liked the staff who cared for them. One person told us, "All the staff are nice and friendly, no problems." A second person said, "I like being here, staff are all very good and nice to me." When we asked another person what they thought of the home and staff, they said, "It's as good as it could be. The staff are good. They treat me with respect." A fourth person said of the staff, "They're all right here. She's okay (pointing to a staff member) and her (another staff member), some others aren't," however they did not elaborate on this further. A fifth person said, "Staff are lovely, get on really well." A relative said "Can't praise the home enough, it's like home from home. Really good, really nice staff, they understand dementia." They went on to say, "They made it so good for her. Absolutely great to us, their hearts are in the right place."

During observations of care and support we saw staff treated people well and with dignity and respect. Staff shared jokes with people and it was clear that good positive relationships had developed between people and the staff team. A relative described staff as having "a good sense of humour." People looked comfortable in the company of staff and we saw people smiling and greeting staff warmly when they entered rooms, putting their arms out for a hug. We saw when people became distressed, staff recognised the signs and responded promptly and appropriately.

People were well dressed and presented which indicated their personal care needs were met by the service.

Staff we spoke with demonstrated an in-depth knowledge of the people they were caring for. The activities co-ordinator had created life histories of people who used the service to aid staff understanding of the people they were caring for. Staff and the management were aware of people, their life histories and routines. For example, one staff member demonstrated a detailed knowledge of one person's daily routines, anxieties and behavioural triggers. They described how this knowledge was used to ensure the person received regular personal care whilst reducing distress. The registered manager had recognised a need for male care staff to build care and support relationships with a number of the male residents in the home. A male member of staff told us how they had been moved onto care from an ancillary role at the registered manager's request. We saw this had been successful with the staff member building good rapport with male residents and demonstrating an in-depth knowledge of their individual care needs.

Relatives reported no restrictions on visiting times and said they were able to visit when they wished. A relative told us, "Can visit any time you want, they have been absolutely wonderful." During the inspection we saw people visiting their relatives, the service made arrangements to give families necessary privacy to spend time with their relatives. We saw a small group of people and a relative sitting together chatting and enjoying a hot drink and cake in a quiet lounge.

We saw a person centred approach to care and support. People said they felt listened to and their choices and preferences were respected. One person told us how they preferred to get up late in the morning and have their lunch and breakfast later than other people. They said the kitchen were aware of this and always served them food at times that met their preferences. They told us, "I feel listened to, they are friendly." During the inspection we saw staff gave people choices as to what they wanted to do and these choices

were respected. This included being aware of verbal and non-verbal communication techniques and the use of pictorial menus and show plates to help people make informed choices. People's views and opinions were gained through many mechanisms, including through informal discussions with staff, care plan reviews and annual surveys.

People's future wishes were gained and end of life care plans put in place. We spoke with one relative who could not praise the home enough and said that everything had been put in place to ensure their relative had a comfortable stay in the home.

## Is the service responsive?

### Our findings

People and relatives we spoke with told us that care needs were met by the service. During observations of care and support we saw staff were aware of people's individual needs and requirements and understood the plans of care needed for each person to provide them with appropriate care that met their needs. This included awareness of nutritional and behavioural care plans for people deemed at risk.

However, care and support records did not provide a complete and accurate record of people's care and support. Since the last inspection, care and support plans had been transferred onto an electronic care management system. Care plans had been produced for a range of areas such as moving and handling, nutrition and end of life care as well as for any specific risks to each individual for example diabetes. However, the computerised care records did not reflect the personalised care we saw being delivered or the knowledge staff had about people's individual preferences. Care plans contained very generic statements such as "Staff to be aware of person's likes/dislikes" and "Staff to refer to dietician for assessment if required" and lacked personalised detail. We identified two people who were nutritionally at risk. Their care plans were not personalised and did not provide clear instructions to staff on how to reduce the risks associated with poor nutrition. Although we were assured through looking at records of contact with health professionals, reviewing daily records and speaking with staff that appropriate plans of care were in place for these people, this was not reflected in the records we reviewed. In two people's care plans advice on the correct setting for their air mattress setting was not recorded. Another person's behavioural care plan said staff should be aware of their triggers but these were not specified in care plans. Care plans were reviewed monthly by the registered manager or deputy. Updates often showed no changes to the plan of care when in fact changes to the care and support arrangements had been made.

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

Electronic daily care records provided evidence of the care and support provided to each person. We looked at these which were generally well completed and saw people received regular checks on their health and welfare.

Periodic care reviews took place with people and their relatives. We looked at these and saw people's comments and views were recorded and acted on. Responses we reviewed were overwhelmingly positive showing people were very happy with the standard of care and support provided.

An activities co-ordinator was employed who undertook a range of bespoke activities to help meet the needs of people living with dementia. They worked five days a week and a mixture of morning, afternoon and evening shifts to ensure people had stimulation at different times of the day. Activities were organised into a two week rolling agenda, with activities planned for six hours each day. This included group and individual activities focused on stimulating the senses. This was complimented by external visitors such as a "music man" who regularly visited the home. The home also utilised volunteers which took some pressure off care staff and improved the amount of social interaction people living in the home received.

The complaints procedure was displayed in the home. No concerns were raised with us during the inspection by people and relatives and they all said they were satisfied with the way complaints were managed. We looked at the complaint records which showed one complaint had been received since the last inspection. This was well recorded and showed the action taken to resolve the complaint as well as how the outcome was feedback to the complainant. People and relatives were able to raise concerns through various mechanisms including family care reviews and informal contact with the registered manager who was involved in daily care and support tasks.



## Is the service well-led?

### Our findings

Systems to assess, monitor and improve the service were in place but they were not sufficiently robust. Issues that we identified at the previous inspection had not been fully addressed. For example, at the last inspection we found topical medicines such as creams and 'as required' medicines were not managed in a safe way. This was still the case at this inspection, demonstrating the service had not fully acted on our feedback to make improvements. We found this was mostly down to problems associated with the electronic care management system. Whilst it was encouraging that the registered manager had a clear vision for improving the service through electronic record keeping, to date, it had not been fully successful. Weekly and monthly medicine audits took place. However these did not look at the way topical medicines such as creams were managed demonstrating a shortfall in this area.

At the last inspection, we found care plans did not always reflect people's care and support requirements. Although efforts had been made to address this through the introduction of an electronic care recording system, we found care plans were not person centred and did not reflect people's care and support requirements. In addition, care plan audits did not take place. The registered manager told us care plans were checked during monthly reviews, however this system was not sufficiently robust to evaluate whether care plans were of the required standard and contained the necessary information and risk assessments. Environmental audits were undertaken, however they were not sufficiently robust as they had not identified some of the issues we found during the inspection such as unstable wardrobes.

Incidents and accidents were recorded. We saw that in some cases preventative measures were recorded on the incident form however this was not consistently the case and care plans were not always updated with preventative measures following incidents. Some individual analysis took place, for example reviewing the falls of an individual to look for themes and trends, although there was no overall analysis of incidents to look for overall trends such as particular time periods or the locations where falls occurred.

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

Staff meetings were regularly held and these were an important mechanism for addressing care quality issues. We saw issues such as the poor documentation of care and support tasks had been discussed with care staff to drive improvement in these areas.

A registered manager was in post who had worked in the role for several years. The registered manager was very 'hands on' and spent a significant amount of time overseeing the care and support being delivered by staff as well as regularly undertaking care and support tasks. For example, they regularly administered the morning medicines round, including on the day of our inspection, both to take pressure off existing staff and monitor the medicines management system. The manager started work at 6.30am each morning. They told us that this enabled them to participate in shift handover, and speak with night staff before they left, as part of a strategy to provide oversight and leadership to the home.

People and relatives all spoke positively about the way the service was run. They confirmed that the registered manager was heavily involved in care and support. Staff said the home was a nice place to work and that morale was good. Staff told us the team worked well and they felt able to raise issues with the deputy or registered manager.

We saw the registered manager sought best practice guidance and specialist training in order to stay up to date with the latest dementia care best practice. For example, they consulted NICE guidelines and had recently completed a university dementia course to further improve the quality of dementia care within the home. We observed a positive and person centred atmosphere within the home where staff were keen to deliver personalised dementia care in line with people's individual likes and preferences.

People's feedback was sought on the service and their views were taken into account in order to improve the service. Although resident and relative meetings had been tried in the past, the registered manager said they were not well attended and they found individual meetings with people more valuable. Care records demonstrated people and relatives were involved in reviews, where issues could be raised to help improve the service. Feedback from review meetings was mostly very positive indicating people and relatives were satisfied with the care received. The findings of the previous CQC report had also been discussed with relatives on an individual basis. Annual quality surveys were also undertaken. We looked at the results of the most recent survey which were positive. Comments included; "Ashville is a home from home," "Manager is always in tune with everything," "The staff are very helpful nothing too much trouble" and "The staff are amazing, always willing to ensure everyone is happy."

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

| Regulated activity   | Regulation  |
|--|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>(1)<br>(2a) (2g)<br>Medicines were not always managed in a safe or proper way.<br>Risks to people's health and safety were not always assessed and mitigated. |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>(2)<br>Systems and processes were not operated effectively to protect people from the risk of abuse.                     |
| Regulated activity   | Regulation  |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>(1) (e)<br><br>The premises was not properly maintained  |

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 | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>(1) (2a) (2c) (2e) (2f)</p> <p>Systems and processes were not operated effectively to ensure compliance with the regulations of the Health and Social Care Act 2008 (regulated activities 2014) regulations.</p> <p>A complete and accurate record was not maintained of each service user's care and support and the decisions in relation to their care and support.</p> <p>The service had not acted on the feedback from the commission to adequately improve the service.</p> |

### The enforcement action we took:

A warning notice was issued requesting the provider to become compliant with the regulation by 8 May 2017.