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 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 18 people were living at the service. The service had two buildings, the building named the annexe, was for male service users only and the main house was 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 had made some improvements to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture, but further improvements were needed.

Right support:
• Improvements had been made to involving people in activities of their choosing and creating enhanced opportunities for people.
People's requests were not always respected by staff.
• There were adequate numbers of staff to support people.
• Some improvements had been made to the décor of the service to make the spaces a more homely environment, but further work was needed.

Right care:
• People continued to not be protected against potential abuse.
• Observations showed that in practice people were not always treated in a dignified manner by staff.
• People were supported to attend meetings and give feedback about the service.
• The majority of people were happy with the care they received at the service.
• Care plans were reflective of people's support needs.

Right culture:
• It had taken the service a long time to implement competent leadership to drive change and this had affected the progression of improvements to the service.
• Notifications about incidents of abuse to people had not been made to CQC.
• Staff told us the culture of the home had improved and this was having a positive impact on people and the way staff supported them.
• Staff demonstrated good understanding of people's needs.

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 20 August 2021) and there were multiple breaches of regulation. There is a condition on the providers registration to submit a monthly action plan of improvements they undertake in the service. This service has been in Special Measures since January 2021. During this inspection the provider has not demonstrated that all of the necessary improvements have been made. The service remains rated as inadequate overall for a third consecutive time.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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.

This report only covers our findings in relation to the Key Questions safe, caring, responsive and well-led. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

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 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.

We have identified a new breach of Regulation 12(3) in relation to staff vaccination records not being recorded in line with the department of health requirements. The provider remains in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 10, failure to ensure people were treated in a dignified approach, 13, the failure to safeguard people from abuse, 17 good governance and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, the failure to notify of incidents of abuse.

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 continue to monitor information we receive about the service until we 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 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 caring 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 medicines inspector.

Service and service type
Ashgables House 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. A manager had been in post at the service since 24th May 2021 and had submitted an application to be registered.

Notice of inspection
We visited the service on 13 December 2021, this visit was unannounced. We returned on 15 December 2021 and announced this second visit to the provider.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service about their experience of the care provided. We spoke with 12 members of staff including the head of compliance, quality assurance, home manager, deputy manager and care staff.

We reviewed a range of records. This included eight people's care records, eight people's monitoring records and multiple medication records. 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 received feedback from four 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.

Preventing and controlling infection
At our last inspection on 17 June 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 remains in breach for a third consecutive time.

- From 11 November 2021, staff working in care homes, and any visiting professionals are required to be fully vaccinated for COVID-19. The Department of Health guidance on demonstrating evidence of staff COVID-19 vaccination status outlines which forms of evidence are acceptable An individual's NHS appointment card should not be accepted as sufficient evidence.
- The service had not gathered sufficient evidence to ensure all staff had received both COVID-19 vaccinations. The manager had gathered some evidence to demonstrate staff had received their vaccinations, which they showed us however, this was not an acceptable form of evidence listed by the department of health guidance.
- The provider's action plan sent 3 January 2022 stated they had collated staff COVID-19 passes in November 2021. This had not been done when we checked at this inspection. We contacted the provider to further request this and the information was sent on 5 January 2022. The checks showed that the staff passes had been seen but did not record the individual dates they were checked, like it did for other visiting professionals.
- We have signposted the provider to resources to develop their approach.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

- Staff were wearing PPE appropriately and were observed following infection control guidance at the time of our inspection.
- The service was observed to be clean and tidy.
- There were clear processes in place for staff to support people to be visited by friends and family during the pandemic.
- Evidence of visiting professional's vaccination status was being checked appropriately by the service.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
At our last inspection on 17 June 2021, we found the service had failed to safeguard people from abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remained in breach for a

second consecutive time.

● There were systems in place to safeguard people, however these were not always being followed appropriately.
● Investigations of Incidents were not always investigated or safeguarded appropriately. For example, we saw one allegation of a staff member making inappropriate sexual comments to a person living at the service. There was no record of this incident being investigated or safeguarding processes being followed. The person who made the allegation was told by staff they could get the staff member and themselves into trouble by making this allegation. This did not ensure people were supported appropriately to feel comfortable and confident to raise any concerns they had. The registered manager told us they had spoken to the person involved however confirmed this had not been recorded.Following our inspection, the registered manager provided us with evidence that a recorded investigation had now been completed.
● We saw that one person had three bruises recorded on a body map in October 2021. One bruise was on the person's hand, another on their abdomen and a third in an intimate area. It was not known how this person had obtained these bruises and the manager said this person had been unable to say. A further bruise was recorded in December 2021. There was no evidence this had been investigated or actions taken to ensure the person remained safe from potential abuse. The manager further confirmed they had not yet raised a safeguarding for these incidents.
● One person however told us they "wanted to leave Ashgables and did not feel safe." This person said they were pushed out of the way by night staff when they wanted to watch TV in the evenings and that it was switched off by staff. We saw this person raise this complaint with a staff member who said they would tell the night staff they wanted to stay up this evening. There were no recorded incidents when this had been raised by this person or evidence of an investigation.
● There was not always sufficient detail recorded within incident forms to consider mitigating future risks. This included incidents where people had physically abused staff and did not consider the future actions that should be taken to reduce the risk.

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.

● The majority of people told us they felt safe living at Ashgables and that "staff were kind and caring" to them.
● Staff told us that they knew how to report concerns and were confident that concerns raised would be managed appropriately. One staff told us, "I believe that if there was any concerns I raised the management would deal with it effectively."
● Staff told us that incidents were being discussed and we saw a new document had been put in place the date this inspection had started, to reflect on practice following incidents.

Using medicines safely
At our last inspection on 17 June 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 although further improvements were needed, the provider was no longer in breach of this regulation.

● Staff had addressed some of the issues from the last inspection and we saw improvements to the way medicines were managed in the home. However, further improvements are needed.
● No gaps were observed in the administration records reviewed, including that for topical creams. Daily

audits and records of medicines were completed twice daily.
● Pain monitoring tools were available to staff within the medicine rooms and a member of staff described how they recognised pain in one person.
● Staff received training in medicines and competencies were complete and recorded.
● People were encouraged and supported to administer their own medicines where this was safe.
● People did not always have a photograph attached to the medicines record as per medicines policy. This could lead to errors in administration. We also found some out of date information within records. The provider should ensure that information about people's medicines needs is reviewed to ensure it is consistent between care plans and separate information within the medicine record.
● Care plans for specific conditions such as diabetes and epilepsy were not complete however this has been actioned since the inspection.
● On the inspection we found that medicines were stored behind locked doors however these were not stored in accordance with the provider's medicines policy, the cabinet was broken. Since the inspection, a risk assessment has been completed, action has been taken to minimise the risk with a padlock and a new cabinet ordered.

Assessing risk, safety monitoring and management
At our last inspection on 17 June 2021, we found the service had failed to provide safe care and treatment to people by mitigating risks. 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 taken the necessary action to make improvements and meet this part of the regulation and was no longer in breach.

● People's individual risks had been assessed and management plans were available to staff to guide them on how to reduce risk to people. Although at times the risk assessments provided limited information on mitigating the risk, there was clear detail recorded within people's individual care plans.
● Staff demonstrated they had enough information available to understand the risks to people and support them effectively commenting, "I feel all risks are well managed and I have enough information in care plans to care for residents and keep them safe. I sometimes feel staff do not have enough time to read them thoroughly" and "We have monthly meetings talking about our residents, their needs and risks, we all work together to manage and review the residents' risks."
● We saw staff were recording any changes to people's skin and monitoring this regularly if a person was not independent in managing their own personal care.
● Behaviour support plans were not in place for everyone who needed this. We were told this was an ongoing piece of work. We did see people's needs recorded in mental health and wellbeing support plans and staff were confident in supporting people with these needs. One health and social care professional told us improvements had been made commenting, "I would say this has improved. They have initiated referrals when service users requires mental health assessment and have asked for support in doing this when required."

Staffing and recruitment
At our last inspection on 17 June 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 for a second consecutive time. At this inspection improvements had been made to staffing levels and the provider had met this breach.

● During both inspection visits we saw that people were being supported by sufficient numbers of staff.
● The provider had recruited a full time cleaner and regular agency staff had been sourced to ensure staffing numbers were adequate.

● A staffing tool was now in place to calculate the numbers of staff required to meet people's needs.
● Staff told us there was more staff now and regular agency staff covered any shortages. Staff commented, "We are getting there, it's much better than it used to be. The manager is good at getting agency staff if needed" and "I feel that we do not have enough staff but due to the shortage of care staff in England this is difficult to recruit and get agency. We have good agency staff that does work at Ashgables and know the residents."
● We observed that staff were responsive when people requested support. One person told us, "There are enough staff and they are nice people."
● No new concerns or intelligence had been received regarding staff recruitment records. We therefore did not review these as part of this inspection.

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 17 June 2021, we found that there had been a failure to ensure people were treated with a dignified approach. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that although some improvements had been made there were still areas of continued improvement needed. The provider remained in breach of for a third consecutive time.

● During this inspection we saw some examples of practice where people were not treated respectfully or in a dignified manner. The response from staff at times demonstrated the service was staff led rather than people led.
● One person told us several times during this inspection that they wanted to move from Ashgables due to not being happy. On one occasion this was said to a staff member and the staff member responded that this person could go and live in another care home and to talk to their social worker. The information was not shared with the management team so they could appropriately take this further with the person or inform the relevant people involved in this person's care. We saw that it was a condition of this person's deprivation of liberty safeguards (DoLS), that if they said they no longer wanted to be in the home, the relevant representatives should be informed.
● We raised this with the registered manager who told us they would take immediate action. Following the inspection, the registered manager provided us with evidence that relevant healthcare professionals had been informed of this person's wishes in line with DoLS conditions.
● Staff told us that everyone was checked throughout the night on a three hourly basis and this was recorded. This was not a person-centred approach for people who did not want to be checked and had not been asked or involved in this decision. People were aware these checks were taking place and one person told us it was not necessary for staff to check on them. No other less intrusive measures had been considered in place of these checks and the manager told us they were not aware that staff were checking people until we raised this.
● Staff were not always deployed effectively during the shift to ensure that time was spent with people engaging them. During our inspection we observed four staff members sat in the dining room completing paperwork for an hour. The staff were responsive when they were approached by people, but they did not interact with them otherwise during this time.
● One person asked if they could go the lounge to watch television. We observed a senior staff member

attempt to discourage this person by saying no one else was in the lounge, however this person said they still wanted to go. Instead of asking care staff to come and assist this person immediately the senior staff member said they would tell the night staff who were due in 20 minutes. We observed that this was told to night staff and that they had tried to discourage the person but they were still wanting to go. The management told us that this person would often go to the lounge and then change their mind but agreed staff should be responding to their wishes regardless.

● We saw that terminology had improved in written records and staff were including more meaningful and respectful comments. We saw a couple of entries that referred to people as being 'demanding' and having a 'dry night' but this had reduced greatly.

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

● The majority of people told us they were happy, felt safe and that there were enough staff who were kind and caring. One person said they were able to freely go for walks and although they did not have the code for the gate, staff would open it when asked.

● Staff felt they were working better as a team to meet people's needs with one staff member saying, "Certain staff have gone, we are more of a team again, we have learnt if someone is struggling to help them and when to help." Another staff said, "My colleagues are treating our residents with respect and good manners, offer them support and respect their choices and wishes."

● We observed that people were comfortable to approach staff and share a jovial conversation. Health and social care professionals told us that people appeared happy living at the service. One professional said, "From reviews carried out they are confident in how the team support service users and that the service users are happy living at Ashgables and most have been living there for many years."

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 rated as requires improvement. At this inspection this key question has remained the same. 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
At the last inspection in June 2021 the provider had failed to support people's autonomy, independence and involvement in their community. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection improvements had been made and the provider was no longer in breach.

● Activities had improved. There was now a structured plan of activities for a month in advance, with a timetable that identified three planned activities for everyday – morning, afternoon and evening. There was evidence that activities had taken place, including records, artwork, posters, and discussions with people. There were activities identified to take place whilst the activities coordinator was on leave. There was an activities noticeboard where people could see what was planned over the coming week.
● The activity staff member was no longer juggling care shifts due to staff shortages and had been able to concentrate on their role and improve outcomes and opportunities for people. People spoke positively about the activities that they had been doing and people knew what was planned over the coming days. One professional told us, "From reviewing care plans and speaking with staff they were aware of people's likes, dislikes, activities they enjoy and had good understanding of family relationships."
●Prior to each activity taking place there was a detailed written plan, that identified what was needed to make the activity happen and goals that were hoped to be achieved. Following each activity, there was a person-centred review of the activity that reflected and identified achievements and lessons learned from the activity, as well as looking at why things may not have gone to plan and what could be done differently to make the activity more successful next time.
● There was recorded evidence of conversations that the activities coordinator had had with people about what activities they would like to participate in, as well as the level of engagement that people had had in each activity. We saw that over time, records showed that people began to increase their engagement with activities. One person had been involved in planning their birthday celebrations including the location, food, music and ensuring their favourite song was played.
● There was evidence that the activities coordinator had tailored activities to meet the needs of individual people, they recorded a set of questions to explore people's backgrounds, history and interests. This resulted in positive outcomes for people, for example, it identified that one person used to play the guitar as a child, and that they would like to start doing this again. This resulted in the service acquiring a guitar for the person.
● We spoke with the management team about increasing the focus to explore people's short and long term goals and were told this work was planned for January 2022. During the inspection we saw some people independently leaving the service to go shopping but staff on duty did not always engage people in

proactive activities in the absence of the activity co-ordinator.

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

● Each person had a care plan in place that was specific to their needs and care support. We saw that these had and continued to be reviewed to ensure they remained relevant. One professional told us, "Since the new care plan have been in place staff have been following this and have asked for review and it has made an improvement in the person's long-term condition."

● We saw that further improvements were needed in some monitoring records where people had specific medical conditions. For example, one person who was at risk of pressure ulceration, the guidance said to monitor their skin but did not say how often this should be checked.

● Another person was having their fluid monitored due to risk of drinking excessive amounts of water. Their care plan stated that if their fluid goes over three litres staff should take action to reduce their intake. We saw however the totals of fluid were only being calculated at the end of the day rather than as fluid was ingested, in order to take timely action if needed. This person had drunk over three litres on two occasions but had not come to any harm.

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.

● We saw that the provider's complaint procedure was displayed in a pictorial format for people who may need it in this style.

Improving care quality in response to complaints or concerns

● No new concerns or intelligence had been received regarding the provider's complaint processes. We therefore did not review these as part of this inspection.

End of life care and support

● No one in the service was currently receiving end of life care.

● No new concerns or intelligence had been received regarding end of life care. We therefore did not review these as part of this inspection.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection on 17 June 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 third consecutive time.

● At the time of this inspection a registered manager was not in place. A manager had been in post at the service since 24th May 2021 and had submitted an application to be registered.
●The service had implemented quality monitoring systems within the service; however, these were not always effective in identifying areas of improvement to take timely action. For example, records of alleged or actual abuse that should have been made to CQC had been reviewed, but it had not been picked up that a notification should have been made. Two professionals told us that whilst there had been improvements they remained less convinced by the management's understanding with one commenting, "At the start management were not addressing the initial actions identified in a timely manner and there appeared to be little urgency or understanding of the importance of the actions. I feel they have now made improvements, but I am concerned about their ability to sustain the higher level requirements needed to maintain a safe and effective service."
●The quality monitoring of documentation completion was not always effective or accurate. For example, we saw staff were signing cleaning checklists ahead of the times they should be checked. Although during the inspection we saw bathrooms were clean, we did not know if staff would check these again as the sheets were all pre-signed. One staff member told us that unfortunately staff did do this sometimes. This meant managers would review the signed sheets and assume staff were completing quality checks appropriately at the stated times, but this was not the case. We raised this with the management team to further address. One staff told us, "I feel that at times there isn't always enough time to complete all jobs required."
● Incidents including medicine errors were recorded however the investigation of these was not always sufficient to ensure preventable measures to mitigate future risk had been taken.
● The service had failed to meet the condition of their registration in September 2021, in which a monthly action plan must be submitted to CQC. The provider said this had been an oversight.

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.

● The provider had struggled to put in place a management team who had clear oversight and understood how to make effective changes. The provider told us this was due to staff sickness within the management team. In light of this, the provider deployed additional support from their head of compliance and quality assurance team, which was making positive impacts.
● The quality team had started a piece of work in re-reviewing care plans to look for key themes and ensure that care plans were consistent, thorough, person centred and a true reflection of people's needs. The head of compliance told us they were supporting the service now for as long as was needed and did not plan to withdraw this resource until it was more stable.
● The service had begun to apply and demonstrate how it was embedding the principles of right support, right care and right culture and improving outcomes for people.

At our last inspection on 17 June 2021, we found that there had been a failure to notify incidents of abuse. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection the provider had continued to fail to notify events and remains in breach for a second consecutive time.

● Three notifications of alleged or actual abuse had not been reported to CQC in line with the provider's registration requirements. The appropriate actions to safeguard these people had not always been followed.

The failure to notify of incidents of abuse is a continued 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
● Staff told us there had been much improvement in staff morale since our last inspection, one staff member told us "It's improved a lot from what it was in January, and when [CQC] came out in the summer. We have a regular manager in place, head office management, and [Quality Assurance]. Having that support there, it's so much better." Other staff said, "It's a lot happier, I am within myself. The residents are not just residents, they are extended families. The deputy manager is amazing. She has a personality to die for, she's very good with residents" and "The morale of the staff seems to be good because we have good staff working in a team and we have a very good communication between us which helps us to work better and support each other."
● Most people we spoke with told us they were happy at the service and knew and liked the staff and the manager. Professionals told us there had been improvements in the communication they received from the service commenting, "Communication has improved. Management email me regularly with safeguarding concerns or if someone's mental health is declining" and "Yes, I always get an immediate response where I contact Ashgables."
● Staff told us they felt much more supported by the management team who were supporting the home. Comments included, "I have a good relation with both the managers", "The morale of the staff has improved because we have support from the head office and our manager and the staff feel more secure and confident when it comes to work" and "Everyone cares, we've had other senior managers in too, the support is so much better now."
● Support systems had been put in place for staff to encourage their morale and wellbeing. The internal quality team had set up a team building day for staff and are planning more going forward. This matched staff together who did not normally work together to encourage more unity across the team. Attitudes and values training was booked for staff in January 2022 and a mentoring programme had been set up. Staff told us the deputy manager regularly spent time supporting staff on the floor and this manager told us, "It's

about demonstrating, I wouldn't ask staff to do something I wouldn't expect to do myself."

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

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

● The management team understood their responsibilities under the duty of candour.

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

● The service engaged people, their relatives, staff and professionals to take up the opportunity to provide feedback about Ashgables. We saw the most recent feedback survey had been completed in August 2021 and responses had been positive. Some people in the service were unable to independently complete the survey and staff supported them to do this. We spoke with the management team about having more neutral support for this so people would be able to voice any concerns if they needed too.

●People and staff had the opportunity to be involved in meetings to discuss the running of the service. People were aware of residents meetings that took place, some people told me that they attended the meetings, others told me that they chose not to attend, but that they were then informed of what had happened at the meetings by staff.

● Staff representative meetings had been implemented so nominated staff could share the wider team's ideas, concerns and feelings to enable them to be heard in a neutral way.

Continuous learning and improving care; Working in partnership with others

● Staff told us improvements had been seen within the service. Comments included, "People are given more choice and are encouraged to join in with activities. Improvements in infection control and new bathrooms and general repairs" and "They are doing a lot of improvements around the home flooring, curtains up, it doesn't feel cold anymore."

● Senior management were working closely with the service to provide support and make improvements. During the inspection the management team shared their intentions and assurances to continuing to improve the service for people living there.

● External professionals told us they had seen improvements within the service commenting, "I believe that Ashgables have made significant improvements over the last year. There is now a manager and deputy manager in place and Allied as an organisation are providing much more support to the team than they have done previously" and "Improvements have been made in regards to care plans and treatment plans."

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 There was a failure to gather sufficient evidence of staff vaccinations in line with legislation. Regulation 12(3).