Mauricare Limited

Ashview House Residential Care Home

Inspection report

Aynsleys Drive
Blythe Bridge
Stoke On Trent
Staffordshire
ST11 9HJ

Tel: 01782398919
Website: www.mauricare.com

Date of inspection visit:
04 September 2017

Date of publication:
09 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 4 September 2017. This was an unannounced inspection. Our last inspection took place on 12 January 2017. At that inspection, we identified a number of Regulatory breaches and we told the provider that improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and remained under special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

As a result of previous enforcement action, a condition was placed on the provider's registration with us that prevented them from admitting and re-admitting people to the service without our authorisation. This condition was made to promote people's safety and remains in place. This condition has been breached by the provider since our last inspection and we are taking action to address this.

The service is registered to provide accommodation and personal care for up to 22 people. People who use the service may have a physical disability and/or mental health needs, such as dementia. At the time of our inspection nine people were using the service. However, one of these people was in hospital as a result of a safety incident that had occurred at the service.

There was a registered manager at the home. 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

and associated Regulations about how the service is run.

At this inspection, we identified a number of continued and new Regulatory breaches. The overall rating for this service remains 'Inadequate' and the service therefore remains in 'Special measures' whilst we continue our enforcement action.

We found that the provider continued to have ineffective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

A notifiable safety incident had not been reported to us, which meant that we could not accurately monitor safety at the service.

Risks to people's health, safety and wellbeing were still not always assessed, planned for, managed and reviewed to promote people's safety.

Safe recruitment systems were still not in place to ensure staff were of suitable character to work with the people who used the service.

Safety incidents were not always analysed and responded to effectively and promptly, which meant the risk of further incidents was not always reduced.

Medicines were not always managed safely.

Some people told us they still experienced occasional delays in receiving the care and support they required. Staffing levels were not consistently reviewed to ensure safe staffing levels were maintained.

We were still not assured that people's health needs were consistently monitored and advice from health care professionals was not always followed to promote people's health, safety and wellbeing.

Accurate records were not maintained to show staff had received the training they needed to meet people's needs and keep people safe. Staff reported that they had not received all the training they required.

An effective complaints system was not in place to ensure complaints were recorded and managed appropriately and promptly.

Deprivation of Liberty Safeguards (DoLS) requests were made when restrictions were placed on people. However, these were not always completed in line with the Mental Capacity Act 2005 (MCA). People's capacity to consent to their care was not regularly assessed and reviewed in line with the MCA.

Some improvements had been made in relation to people's receiving care that met their individual care preferences. However, further improvements were needed to ensure people could access activities that were meaningful and therapeutic to them.

Although people were involved in the initial planning of their care, they were not involved in regular reviews of their care to ensure their care preferences had not changed. This meant people were at risk of receiving care that did not meet their changing preferences.

People could choose the foods they ate, but detailed information about people's specialist dietary needs

was not always readily accessible to ensure consistent care.

Some people spoke fondly about the staff and at times, we observed some positive interactions between staff and people. However, we found that people were not consistently treated in a dignified manner.

People were supported to make day to day choices about their care and the choices people made were respected. People's right to privacy was promoted.

Staff knew how to identify and report incidents of potential abuse and neglect.

The provider was now displaying their inspection rating on line as required.

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. Risks to people's health, safety and wellbeing were still not always assessed, planned for, managed and reviewed to promote people's safety.

Effective systems were still not in place to ensure staff were suitable to work with the people who used the service.

Medicines were not always administered safely.

Some people told us they still experienced occasional delays in receiving the care and support they required. Staffing levels were not consistently reviewed to ensure safe staffing levels were maintained.

Staff were trained to identify incidents of potential or alleged abuse.

Is the service effective?

Inadequate

The service was not effective. People's health needs were not effectively monitored and managed and professional advice was not always sought or followed to promote people's health, safety and wellbeing.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure people's ability to consent to their care was assessed and reviewed.

Staff did not always have the knowledge and skills needed to meet people's needs effectively and safely.

People could choose the foods they ate, but detailed information about people's specialist dietary needs was not always readily accessible to ensure consistent care.

Is the service caring?

Requires Improvement

The service was not consistently caring. People's dignity was not always promoted.

People were supported to make day to day choices about their

care and the choices people made were respected.

People were supported by staff who knew their likes and dislikes and people told us the staff were kind and caring.

People could access private areas of the home when they wished to do so.

Is the service responsive?

Inadequate

The service was not responsive. People were not always supported to participate in social and leisure based activities that were meaningful or therapeutic to them.

An effective system was not in place to ensure all complaints were recorded and managed to improve people's care experiences.

People were involved in the initial planning of their care. However, they were not involved in reviewing their care needs. As a result, people were at risk of receiving unsuitable care as their care preferences changed.

Is the service well-led?

Inadequate

The service was not well led. The registered manager and provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to respond to themes relating to safety incidents, so prompt action was not always taken to reduce the risk of further harm occurring.

The registered manager and provider did not always report notifiable incidents to us as required.

Ashview House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

We undertook an unannounced inspection of Ashview House Residential Care Home on 4 September 2017. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to formulate our inspection plan.

We checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed the information we had received from the public and the local authority. This included complaints about the service and monitoring visits. We used this information to formulate our inspection plan.

We spoke with five people who used the service, six visiting relatives, six members of care staff, the registered manager and the provider. We did this to gain people's views about the care and to check that standards of care were being met.

We observed how the staff interacted with people in communal areas and we looked at the care records of seven people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff files, rotas and quality assurance

records.

Inadequate

Is the service safe?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people consistently received their care in a safe manner. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that these improvements had not been made and people remained at risk of harm to their health, safety and wellbeing.

The risks associated with people's behaviours that challenged, such as aggression were still not always assessed and planned for. For example, one person's care record showed they had been aggressive towards staff on five occasions in the ten days leading up to our inspection. This person had at times also displayed aggressive behaviour towards people who used, visited and worked at the service. These incidents of aggression had not triggered a re-assessment of the risk this behaviour posed to people and no plans were in place that contained information to guide staff on how to manage this behaviour when it occurred. This lack of guidance meant staff were not equipped to manage this person's behaviour in a safe and consistent manner, as the staff we spoke with gave us different accounts of how they would respond to this person's aggression. This placed people who used, visited and worked at the service at risk of harm to their health, safety and wellbeing.

We found that action was still not always taken to reduce the risk of people sustaining injuries from falling. For example, one person told us they had fallen recently and they showed us the injury they had sustained. An incident form we viewed confirmed this person had suffered an unwitnessed fall two days before our inspection. This fall had not triggered a review of the person's mobility needs or risk of falling again. This meant prompt action had not been taken to assess and manage this person's risk of sustaining further injuries from falling.

We found that people's risk of skin damage was still not always being assessed and managed in a safe manner. One person's care plan stated they needed to use a specialist cushion and be supported to regularly change their position. However, their daily care records that showed the support they received from staff on a daily basis on occasion, referred to specialist boots that were used to protect their heels from skin damage. We saw that this person was not wearing these boots during our inspection, so we asked two staff members if these were required as they were not included in the person's care plan. One staff member told us that the person wore these boots sometimes and the other staff member told us they knew nothing about this person needing boots. This meant we could not be assured that this person's risk of skin damage was being planned for and managed in a safe manner as they were receiving variable skin care from different staff.

Most people who used the service had their medicines from a monitored dosage system where their medicines came in their prescribed doses direct from a pharmacy. We found that where this system was used, people's medicines were administered safely. However, safe systems were not always in place to ensure people received their other medicines consistently and safely. We found that medicines were not always given in accordance with people's 'as required' protocols and the manufacturer's guidance. One person had received one of their 'as required' medicines for a period of 14 consecutive days, despite their

protocol and the manufacturer's guidance stating the medicine should only be administered for five consecutive days. A staff member told us the person's doctor was aware of this, but the staff member was unable to show us a record of that confirmed this had been discussed and agreed by a doctor. This meant we could not be assured that this person had received their 'as required' medicine safely. We also found inaccuracies in the numbers of medicines in stock and the numbers of medicines recorded on another person's medicines administration records. These inaccuracies meant that person could not be assured that they had received their blood thinning medicines as prescribed, placing them at potential risk of blood clots and/or bleeding.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were needed to ensure that staff were suitable to work at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that some improvements had been made, but further improvements were required. We saw that references and criminal history checks were requested to ascertain if staff were of suitable character to work at the service. However, the references in two of the four staff members' files we looked at were not appropriate as these employment references had been sought from staff member's colleagues rather than their managers. This meant we could not be assured that these references were an accurate reflection of their suitability to work at the service as work colleagues would not have access to the information about the referee in terms of their previous competence, skills and overall suitability for the role. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were needed to ensure the staff were effectively deployed to promote people's safety and ensure people's needs were consistently met in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that some improvements had been made, but further improvements were still required to ensure staffing levels were promptly reviewed as and when people's needs changed.

People and their relatives told us that staff were now mostly always present in communal areas to promote people's safety. One relative said, "I've noticed the staff are in the lounge more now doing paperwork". However, we received mixed feedback from people about the timeliness of the staff in responding to their need to access the toilet. One person said, "I can go to the toilet most times when I ask now". Another person said, "They don't always take notice of me when I want the toilet". This meant that some people continued to experience occasional delays in receiving the care and support they needed.

Some of the staff we spoke with us told us that two people who used the service required one to one care and support at times due to their behaviours that challenged and the risks these posed to themselves and other people. Staff told us that despite the changes in these people's needs, no changes had been made to the staffing levels. One staff member said, "If [person who used the service] is here, they take up so much time". Another staff member said, "There's only three staff and [person who used the service] needs one to one. Staffing needs to be improved". We asked the registered manager to show us the dependency tool they used to assess the current staffing levels. The registered manager did not have an up to date version of this tool at the time of our inspection. However, they sent us an updated version the day after the inspection which supported the staffing levels that were in place at the time of the inspection. This showed that although the provider assured us safe staffing levels were maintained, the tool used to ascertain staffing

levels was not kept up to date. This meant there was a risk that safe staffing levels may not be consistently maintained.

At our last inspection, we told the provider that improvements were needed to ensure incidents of alleged abuse and neglect were reported to the appropriate agencies. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw improvements had been made. Staff told us how they would identify, record and report potential abuse and records showed that staff had completed training in this area of care. No incidents of alleged abuse had been identified or recorded by staff since our last inspection; therefore we were unable to confirm that the reporting systems in place were fully effective. We will continue to monitor the provider's compliance in this area of care.

Inadequate

Is the service effective?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure that effective systems were in place to ensure people's health, safety and wellbeing needs were monitored and managed in a safe and effective manner. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and care records showed that they were supported to see health care professionals when they were unwell. For example, one person told us they were supported to access a district nurse at times in relation to their skincare needs. However, we found that the advice of health care professionals was not always followed to promote people's health, safety and wellbeing. For example, one person's care records showed that on two occasions since May 2017, a community psychiatric nurse had asked staff to record a person's behaviours that challenged on an ABC chart. An ABC chart is a tool used to record people's behaviours and their triggers and consequences. This tool can help professionals to assess and monitor people's health and wellbeing. We found that ABC charts were not being used for this person despite their care records showing that they regularly displayed behaviours that challenged, such as aggression and restlessness. This meant effective systems were not in place to ensure professional advice was followed. This placed people at continued risk of harm to their health, safety and wellbeing.

Care records showed that some health monitoring was completed. For example, people's weights were monitored to identify and act upon any changes. However, we found that the systems in place to monitor people's diabetic needs were still not effective. For example, one person's care plan stated their blood sugars needed to be monitored regularly. The plan did not inform staff how often the testing should occur, but staff told us this testing needed to be completed three times a day. This person's blood sugar records contained gaps which showed their blood sugars were not always monitored three times a day. This placed the person at risk of harm to their health, safety and wellbeing as staff were not able to show that they were consistently monitoring this person's blood sugar levels to identify and act upon any changes.

We also found that the information required to enable staff to effectively monitor people's diabetes was not available in the care records. We looked at the care records for two people who lived with diabetes. Information was available to staff to inform them of the symptoms of high and low blood sugars and what they should do in these circumstances. However, no record of people's expected safe blood sugar levels were recorded. When we spoke with staff about people's safe/expected levels we received different answers. This meant staff did not know what blood sugar readings would indicate that an individual's blood sugars were too low or too high for them. One person's recorded blood sugar readings were frequently significantly higher than the recommended safe range set by NICE (National Institute for Health and Care Excellence). This placed them at risk of long term damage to their health. Care records also contained limited evidence to show that action was taken when a high reading was obtained. For example, on 17 recent occasions the person's blood sugar levels were recorded as at least double the recommended level. Care records only showed that action was taken or professional advice was sought on four of these 17 occasions. This meant we could not be assured that the long term risks of significantly high blood sugar readings were being addressed.

When people suffered skin injuries, such as skin tears, pressure ulcers or bruising; body maps were not always used to record the details of the injury. For example one person's care records contained information about three recent injuries they had sustained from three recent falls. These three injuries had not been recorded on body maps. This meant that the person's injuries could not be monitored for changes as the specific details of the site, size and appearance of these injuries were not clearly recorded.

The above evidence shows that effective systems were not in place to ensure people's health, safety and wellbeing needs were monitored and managed in a safe and effective manner. This was an additional and continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we told the provider that improvements were needed to ensure effective systems were in place to gain and review people's ability to consent to their care. At our last inspection, we judged that this was an area for improvement, rather than a breach of Regulation. At this inspection, we found that improvements had not been made. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that people's ability to consent to their care was not reviewed in response to changes in their ability to consent to their care. For example, one person's mental capacity to consent to their care at Ashview had been completed prior to their admission to the service. This assessment judged that the person had capacity to make this decision. However, their consent to care form had been signed seven months later by their next of kin with no reference to the person being involved in that decision. Staff confirmed that this person was frequently confused due to their medical condition, which made their capacity to consent to their care variable. This meant the person's capacity to consent to their care had not been formally reviewed and consent to care was not sought in line with the MCA.

Consent to the use of equipment forms were also in place that had been signed by people who used the service. These forms did not specify the exact equipment the people had consented to, so we were not able to ascertain that people had consented to the specific equipment that they were using.

At our last three inspections, we found that the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) were not consistently met. This meant people could not be assured that they were being deprived of their liberty in a lawful manner. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made. The provider was no longer in breach of this specific Regulation, but further improvements were still required.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw some appropriate DoLS referrals had been made and conditions set within people's authorised DoLS were met. However, we identified one person whose capacity to consent to their care had not been assessed to show they were unable to consent to this part of their care. The DoLS only apply once a person has been deemed to not have the mental capacity to consent to the restrictions placed upon them.

The above evidence shows that effective systems were not in place to assess, record and review people's

ability to consent to their care and the requirements of the MCA were not always followed. This was a new breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that effective systems were not in place to ensure staff were suitably skilled to meet people's needs in a safe and effective manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we were unable to ascertain if improvements had been made as accurate training records were not maintained and staff reported some gaps in training.

We asked to see staff training records. However, these had not been maintained and updated at the time of our inspection. Therefore newly appointed staffs' training records were not recorded. An updated copy of the staffs' training was sent to us after our inspection. We looked at the training records for three staff who had recently started to work at the service. Their training records showed they had received training in areas such as safeguarding, moving and handling and behaviour that challenged. However, the training dates significantly preceded their employment at the service and their staff files did not contain evidence to support they had completed all the training recorded on the training matrix in the past. This meant we could not be assured that these staff members had completed these trainings and gained the skills required to support people safely.

Some staff told us that they would benefit from training/more training in diabetes and behaviours that challenge. For example, one staff member told us, "I've asked for diabetes training" and they confirmed they had not yet received this training. When we spoke with this staff member about a person's diabetic needs, the information they gave us did not match diabetes best practice guidance. However, this staff member's training records showed they had completed this training. This meant that their training records may have been inaccurate or the training they had received had not been effective.

The above evidence shows that effective systems were still not in place to ensure staff were suitably skilled to meet people's needs in a safe and effective manner. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, people told us and we saw that their food and dining preferences were not always met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we saw that improvements had been made.

People told us and we saw that they were now offered a choice of meals and their food preferences were met. However, some people and their relatives told us this was a very recent change that they hoped would continue to remain in place. One person said, "The food has been a lot better this week, there have been various menus". A relative said, "Up until last week [person who used the service] used to complain about the food, there's never usually a choice".

People also told us that their dining experience had improved. For example, one person told us they had requested music to be played at mealtimes and they confirmed and we saw that music was now being played. We saw also that people's preferences as to where they wished to eat their meals was now respected and met.

People and their relatives told us that specialist dietary needs were met. However, the systems in place to ensure all staff followed recommendations in relation to this were not fully effective. This was because information about people's specialist dietary needs was not always readily accessible for the staff to refer to and follow. This meant there was a risk that people's specialist dietary needs may not be consistently met.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we told the provider that improvements were needed to ensure people were consistently treated with dignity and respect. This was not identified as a breach of Regulation. At this inspection, we found that some improvements had been made. For example, staff were recording care interventions using dignified language. However, further improvements were still required to ensure that people's dignity was consistently promoted. People told us they were treated with dignity. For example, one person said, "They don't rush me, they're really good". However, we saw that some care interactions were completed in an undignified manner. For example, we saw that's people's medicines were not always given in a manner that promoted people's dignity as eye drops were administered to people during mealtimes in front of other people who were eating their meals. This meant that improvements were needed to ensure people's dignity was consistently promoted.

People and their relatives told us that the staff were kind and caring. Comments from people included; "Whatever I ask, they do. They are not rude" and, "The staff are nice". Comments from relatives included; "The carers do actually care" and, "I've never come across a carer that's given me cause for concern".

People told us that the staff knew their likes, dislikes and care preferences well. For example, one person told us that since care staff had been covering the cooking tasks in the absence of the cook, they were getting foods that they enjoyed as the staff knew their likes and dislikes well. They said, "It's been really good this week". We also saw that staff knew people well as we heard them talking to people about their interests. For example, we heard one staff member talk to a person about Frank Sinatra which the person confirmed was one of their musical preferences.

We saw that some people were offered choices about their day to day care. For example, we saw one person was given a choice of mugs to drink their cup of tea from. We also saw that the choices people made in relation to their day to day care were respected. For example, when a person asked for their juice to be poured into a glass rather than a plastic beaker, a member of staff respected this choice and poured the juice into a glass as requested.

People told us and we saw they could access private areas of the home when they wished to do so. For example, we saw staff offer and support a person to access a private room to meet with their visitor.

Inadequate

Is the service responsive?

Our findings

At our last four inspections, we found that improvements were required to ensure care was consistently provided in accordance with people's preferences and individual needs. This was an additional breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvements had been made, but further improvements were still required.

People told us they could now bathe when they wished to do so. Comments from people included; "I have a bath twice a week now" and, "I have a bath when I want one". However, people and their relatives reported a reduction in the support available to ensure people were engaged in activities that met their leisure and social based needs and interests. We asked people how they spent their time at Ashview. Comments from people included; "I read and watch TV, there's not a lot you can do here is there?" and, "[We do] nothing really, we used to do more". Relatives we spoke with also commented on the change in activity provision. One relative said, "There's no activities worker anymore" and, "The staff play dominoes with [person who used the service] but most either watch TV or are asleep". Another relative said, "There doesn't seem to be anything going on and [person who used the service] never goes out now". Staff told us they were unable to support everyone to meet their activity preferences as some people who used the service needed a higher level of support from them to promote their safety. This meant some people didn't receive the support they needed to engage in activities that were meaningful and therapeutic to them. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were needed to ensure that concerns and complaints were addressed promptly. This was not identified as a breach of Regulation. At this inspection, we found that improvements were still needed to ensure an effective system was in place to record and respond to complaints.

People and their relatives gave us mixed feedback about how complaints were managed. Positive comments included; "Some things I raise are addressed" and, "I had a word with [staff member] the other week about food and it's altered now". Other comments included; "What [the registered manager] tells you and what he does are two different things" and, "I'm fed up of keeping saying the same things". An example of a common complaint raised by this relative related to problems with the laundering of clothes. We asked the registered manager to see their complaints records. However, the registered manager did not know where this information was located. We asked for this information to be sent to us and following our inspection, we were sent a brief summary of the complaints received. This information did not include the initial recording of the complaints received and the formal responses sent to the complainants. This meant we could not identify if these complaints had been managed appropriately. Concerns and complaints that people's relatives told us they had raised, such as complaints about laundry and food were also not included in the complaints summary sheet sent to us. This meant that some complaints were not being recorded and/or acted upon as required. Not having an effective system to record and handle complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed that people had been involved in some elements of care planning. For example, care

records contained information about people's likes, dislikes and life histories. However, people were not actively involved in the review of their care. This meant there was a risk that as people's preferences changes, staff would not be aware of this and people were at risk of receiving care that did not consistently reflect their care preferences.

Inadequate

Is the service well-led?

Our findings

At our last two inspections, we found that improvements were needed to ensure the home was well-led. At our last inspection, this was identified as a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made. This placed people at risk of ongoing harm to their health, safety and wellbeing.

People and their relatives described the registered manager as, "Warm and welcoming" and, "Kind". However, people and their relatives also told us that they did not always have confidence in the registered manager's and provider's ability to make and sustain improvements to the quality of care. Comments included; "I get the impression from the staff that it's not the best run home", "The staff are nice, but they need leading", "Some things seem to have gone better, but I still feel uneasy" and, "It could be really nice and really good. I'm hoping it can be turned around, but I have my doubts". This showed that some people and their relatives had identified that the service was not well-led.

Effective systems were not in place to ensure the quality of care was effectively assessed and monitored to make improvements. The information contained in people's care records was not being effectively monitored or analysed by the registered manager or provider to ensure the information contained within them was accurate and up to date. For example, we found that one of the two care plan audits completed since our last inspection had not identified that the person did not have an up to date mental capacity assessment in relation to their ability to consent to the restrictions placed upon on them and it had not identified that a plan to guide staff how to manage their behaviours that challenged was not in place. This placed people at risk of harm and showed that effective systems were not in place to ensure people's care records were accurate, up to date and complete.

Effective systems were not in place to ensure people's care needs were being managed effectively. For example, the registered manager and provider had not identified that people's diabetic needs were being effectively planned for or managed in a safe manner as gaps in one person's blood sugar monitoring had not been identified and there was no evidence to show that staff were managing this person's variable and potentially unsafe blood sugar readings. This meant staff did not have access to the information they needed to manage people's health needs in a safe and effective manner. As a result of this, people were at risk of receiving unsafe and inconsistent care.

Safety incidents were not promptly analysed to ensure action could be taken to prevent further incidents from occurring. For example, the incident book contained completed forms in relation to one person's falls from a period of time covering up to 49 days prior to our inspection. This meant the registered manager had not reviewed these incidents during this time to identify if action was required to ensure this person's safety. Incident forms relating to this person showed they had fallen on four occasions during this time. During this time period two visiting health care professionals had recommended that this person receive one to one supervision from staff to ensure their safety. However, no action had been taken to protect this person from the risk of falling by following the professionals' advice as no request for one to one funding was made and no one to one support was put into place. This showed that a prompt and proactive response to address

risk had not been taken to ensure this person's safety.

We found that the provider was not following the actions listed on the action plan that they submitted to us after our last inspection. For example, one of the actions on this plan stated, 'Ensure there is evidence of manager's daily walk around with associated action plans on findings'. Management records showed evidence of three 'walkabout' audits since our last inspection. The last one was dated April 2017. This meant the registered manager and provider were not completing these 'daily' quality checks as planned. We also found that information recorded by the registered manager and provider in their completed Provider Information Return (PIR) was not always completed as planned. For example, the PIR stated, 'Service users are regularly involved in designing what activities they would like for the coming week'. However, people told us they were not supported to participate in activities that met their leisure and social preferences and no activities worker was in post to support people to engage in activities that were meaningful to them. This meant the registered manager and provider did not always make the improvements or provide the quality of care that they stated they would provide.

The registered manager and provider had not maintained accurate records relating to the management of the service. For example, an accurate staff training list was not maintained as the one shown to us during the inspection did not have some staff listed on it. This was also an action listed on the provider's action plan submitted to us after our last inspection which stated, 'Ensure training matrix is current at all times'. The registered manager and provider did not know where complaints records were located when we asked for them. This meant effective systems were not in place to ensure records relating to the management of the service were accurate, up to date and readily available.

In July 2017, the provider contacted us to inform us that they had hired an external consultant to help them to assess, monitor and improve the quality of care at Ashview and the other home's owned by the provider. We saw no evidence to show this action had led to any improvements in quality at the service at the time of our inspection.

The above evidence shows effective systems were not in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered manager and provider had not reported a notifiable incident of a serious injury to us as required under our registration Regulations. This meant we did not have access to important intelligence to help us to monitor safety at this service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In April 2017, the provider was found to be in breach of a condition of their registration with us. A person was readmitted to the service without CQC authorisation. This is an offence under Section 33 of the Health and Social Care Act 2008.

At our last inspection, we found that the provider was not displaying their rating on their website as required. This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the rating was now being displayed as required.