

Ashview House Limited

Ashview

Inspection report

River View High Road
Vange Basildon
Essex
SS16 4TR

Tel: 01268583043

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and 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 supporting people with a learning disability and autistic people and providers must have regard to it.

About the service

Ashview is a residential care home providing personal care to nine people at the time of the inspection. The service can support up to 13 people with a learning disability and autistic people.

People's experience of using this service and what we found

The provider was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support

Staff supported people with their medicines in a way that promoted their independence; however, information about people's medicines was not always accurately documented.

People were supported to make decisions and staff communicated with people in ways that met their needs. Staff supported people to play an active role in maintaining their own health and wellbeing.

Right Care

The provider had not always ensured staff were appropriately skilled to meet people's needs and keep them safe.

The provider had not always completed all relevant recruitment checks prior to staff starting work. We have made a recommendation about safe staff recruitment.

Staff understood how to protect people from poor care and abuse and how to recognise and report any concerns.

Staff and people cooperated to assess risks people might face. Where appropriate, staff encouraged and enabled people to take positive risks.

Right Culture

The provider did not have effective systems in place to monitor the quality and safety of the service. For example, we found concerns with the provider's oversight of staff training and medicines management. People's care documentation had not always been reviewed to ensure it reflected their current needs and preferences.

People were not always supported to engage in meaningful activities and their care plans did not always accurately reflect their future goals and aspirations.

People and those important to them, were involved in planning their care; however, we received some mixed feedback about how well the provider communicated with others.

Rating at last inspection and update

The last rating for this service was Requires improvement (published 3 March 2021) and there were breaches of regulation.

At this inspection enough improvement had not been made and the provider was still in breach of regulations and the service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections

Why we inspected

We carried out an unannounced inspection of this service on 27 January 2021. Breaches of legal requirements were found. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve the safety of people's care and the oversight of the service.

We undertook this focused inspection to follow up on the action we told the provider to take at the last inspection. We also assessed whether the service was applying the principles of Right support, right care, right culture.

This report only covers our findings in relation to the Key Questions of Safe and Well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staff training and management oversight of the service. Please see the action we have told the provider to take at the end of this report.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Ashview

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 Health and Social Care Act 2008.

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

Two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Ashview is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ashview is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with two people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy manager and support workers. We spent time observing people's care to understand the experiences of people who could not talk with us.

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

After the inspection

We continued to review the provider's training and quality assurance documentation and we spoke with two professionals who had contact with the service



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 Requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- The provider had not ensured all staff received relevant, good quality training. The provider's training records evidenced not all staff had completed mandatory training such as moving and handling, safeguarding, infection prevention and control and food hygiene. This meant there was a risk staff may not understand how to support people safely
- Staff did not always demonstrate an understanding people's individual needs and preferences. For example, we received mixed feedback from healthcare professionals who had worked alongside the service regarding how well staff understood people's mobility needs and how to use healthcare equipment safely.

The provider had failed to ensure staff received appropriate training. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider responded to the concerns raised, providing an action plan for improvements and confirming all mandatory training had now been completed.
- The provider had processes in place to recruit staff safely. However, applicant's references were not always checked or verified in line with best practice.

We recommend the provider considers current best practice guidance for the safe recruitment of staff

Preventing and controlling infection

At our last inspection the provider had failed to protect people from the risk of harm caused by poor infection prevention and control measures. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 and the requirements of the warning notice had been met.

- The provider had made improvements to their infection prevention and control processes and people were now protected from the risk of infection. However, improvements were still needed to ensure all staff were suitably trained and followed up to date government guidance for the safe management of COVID-19 risks.
- The provider had increased the frequency of cleaning, including to high-touch areas. However, not all

communal spaces were clean and odour free on day one of our inspection. The provider responded promptly to feedback and no concerns were observed with cleanliness during the second site visit.

- Staff wore appropriate personal protective equipment (PPE) when supporting people and there were measures in place to ensure the safe storage and disposal of PPE.
- The provider had updated their COVID-19 and contingency planning documentation to ensure protocols were in place in case of any future outbreaks of infection.
- Staff were provided with guidance about COVID-19 testing and what actions they should take if people or staff tested positive.

Using medicines safely

- Staff had received medicines training and the registered manager had assessed their competency to administer medicines safely. However, competency assessments had not always been reviewed in line with best practice.
- The provider had not always ensured the documentation in people's medicines folders was up to date and reflected their current support needs. For example, we found medicines care plans and risk assessments which had not been reviewed and signing in and out sheets which were no longer in use.
- The provider completed regular audits of people's medicines. However, we found an error on one person's medicines administration record which had not been identified.
- Following the inspection, the provider sent us an action plan confirming people's medicines documentation was in the process of being reviewed and updated.
- People received support from staff to make their own decisions about medicines wherever possible. One person told us, "I don't always want [name of medicine] as I don't need it, I just tell the staff. I can take my medicines myself or the staff do it."
- People could take their medicines in private when appropriate and safe. The provider had ensured people had individual lockable cabinets in their bedrooms and were able to choose where they would like to be supported.

Assessing risk, safety monitoring and management

- People were involved in making decisions about how to keep safe. People's care plans documented how to support them with making decisions which minimised risks to safety but promoted their independence.
- People had risk assessments in place which were personalised to their needs; however, these had not always been reviewed to ensure they remained up to date. For example, guidelines relating to people's emergency epilepsy medicines had not been updated annually and it was unclear whether the information remained accurate.
- Staff managed the safety of the living environment and the equipment through regular checks and action to minimise risk.
- Staff recognised the signs when people experienced emotional distress and knew how to support them to keep them safe.
- Relatives told us they felt people were safe living in the service. One relative said, "[Person] is as safe as they can possibly be."

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse

- People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse.
- Staff had safeguarding information available and they knew how and when to raise a safeguarding concern. One member of staff told us, "I would tell the manager and speak to them about it so they could raise it."
- The provider was aware of their responsibility to notify the local authority of any safeguarding concerns

Learning lessons when things go wrong

- Staff recognised incidents and reported them appropriately and managers investigated incidents and shared lessons learned.

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 Requires improvement. At this inspection this key question remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection effective systems were not in place to monitor the service and the provider had not followed the duty of candour. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider.

At this inspection, the requirements of the warning notice had been met; however, not enough improvements had been made and the provider remained in breach of Regulation 17.

- The provider's governance processes were not always effective in ensuring people were provided with good quality care and support. For example, the registered manager's audits had failed to identify the concerns we found with staff training, the management of medicines and out of date documentation. Where the provider had highlighted areas for improvement, it was not always clear what actions they planned to take to address these and by when.

Robust systems were not in place to monitor the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager understood their regulatory responsibilities to submit the relevant notifications to CQC and the provider applied the duty of candour where appropriate.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The culture of the service did not always promote people's individuality and enable them to develop and flourish. People lacked meaningful, person-centred activities and there was a lack of documentation to evidence how people were being supported to achieve the goals set in their care plans.

- The registered manager told us some information in people's care plans required updating to better reflect their current goals and activities were not always being recorded appropriately to reflect the personalised activities taking place. Following the inspection, they provided an action plan addressing these concerns.

- The provider asked for feedback from people and those important to them. However, we received mixed responses from relatives about how well the registered manager communicated with them. Comments included, "We sometimes have trouble getting through to them" and, "The old manager used to have regular meetings with us; with the newer one, I've not been invited to any". However, other relatives told us, "It's always been friendly and welcoming" and, "They let us know anything that happens."
- Staff felt able to raise concerns with managers without fear of what might happen as a result. Staff told us they felt supported and valued by the management team.

Continuous learning and improving care; Working in partnership with others

- The provider worked in partnership with other health and social care organisations. However, we received some mixed feedback from healthcare professionals regarding how effectively the provider communicated and shared information with them.
- The provider had implemented a service development plan to monitor improvements in the service. Following the inspection, the provider responded promptly to the concerns raised, confirming what actions they planned to take and providing an updated development and improvement plan.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Robust systems were not in place to monitor the quality and safety of the service.</p> <p>This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had failed to ensure staff received appropriate training.</p> <p>This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>