Mauricare Limited

Ashview House Residential Care Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected this service on 12 January 2017. This was an unannounced inspection. Our last inspection took place in April 2016. At that inspection, we identified a Regulatory breach and we told the provider that improvements were needed to ensure people consistently received care that was safe, effective, responsive and well-led. The service was rated as 'requires improvement'. As a result of enforcement action, a condition was placed on the provider's registration with us that prevent them from admitting and re-admitting people to the service without our authorisation. This condition was made to promote people's safety.

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 11 people were using 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. A home manager had also been recently recruited and the registered manager told us they also planned on registering with us.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into '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.

At this inspection, we found that the provider did not have effective 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.

Recent changes in management had led to people and staff feeling unsettled.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care.

People were not always protected from the risk of abuse because some staff were not trained in how to recognise and report abuse. Suspected abuse was not always reported as required. Safe recruitment systems were 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, which meant the risk of further incidents was not always reduced.

There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

People told us they enjoyed the food. However, we found that some people did not always receive the support they needed to eat. Mealtimes were not a pleasant experience for everyone as they were lengthy and people couldn't always choose where they dined.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not always followed to ensure people were supported to consent to their care. We identified one person who was potentially being unlawfully deprived of their liberty.

We were 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.

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 caring manner. Dignity was not always promoted.

Some people were offered regular choices about their care. However, improvements were needed to ensure all people were offered daily choices about the parts of their care they could make decisions about. Improvements were also needed to ensure staff respected the choices people made.

People were not consistently involved in the planning and review of their care. This meant people's care records did not contain up to date information about their care preferences. We found that people did not always receive care in line with their individual preferences.

Most people told us they knew how to complain. However, we found concerns or complaints about care were not always raised or responded to promptly.

The inspection rating was not being displayed on the provider's website as required by law.

People's right to privacy was promoted. People received their medicines as prescribed.

There was a programme of social and leisure based activities on offer to people that reflected their activity preferences.

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 not always assessed, planned for, managed and reviewed to promote people's safety.

Staff were not always available to keep people safe and meet people's care needs. Effective systems were not in place to ensure staff were suitable to work with the people who used the service.

Some staff were not trained to identify incidents of potential or alleged abuse. We were not assured that all incidents of potential abuse were reported as required.

A new medicines system was in place and people received their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective. The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not always followed and people continued to be potentially unlawfully deprived of their liberty. We could not be assured that people's consent to their care was being sought in line with the Act.

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.

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 their preferences about where and when they ate their meals were not always considered or met.

Is the service caring?

Requires Improvement

The service was not consistently caring. At times people were controlled and restricted by routines, systems and the culture within the home.

People were not consistently treated with care and respect. Dignity was not always promoted.

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

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive care in accordance with their preferences and needs.

People were not involved in reviewing their care needs. As a result, the information in people's care records did not always reflect their current care preferences.

Most people told us they knew how to complain. However, we found concerns or complaints about care were not always raised or responded to promptly.

People were supported to participate in social and leisure based activities of their choosing.

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 action was not always taken to reduce the risk of further harm occurring.

The inspection rating was not being displayed on the provider's website as required by law.

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 12 January 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.

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, a visiting relative, a visiting health care professional, four members of care staff, the registered manager and the newly appointed home manager. 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 six 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 suitable risk management plans were in place and followed by the staff, to consistently promote people's safety. At this inspection, we found that these improvements had not been made and people were at risk of harm to their health, safety and wellbeing.

Some people who used the service told us they felt unsafe at night. One person said, "[Person who used the service] keeps going into people's rooms and we're not allowed to lock our doors". One person's care records showed they had displayed behaviours that placed other people who used the service and the staff at risk of harm and distress. These behaviours included entering people's rooms at night. We found that prompt action had not been taken to protect people from the risks associated with this person's behaviours as action was only taken to help mitigate these risks 33 days after the care records first showed the person had entered another person's bedroom at night. This meant people had been exposed to the risks associated with this person's behaviour for a significant period of time before any action had been taken. This had resulted in people feeling unsafe during that time.

This person had at times also displayed aggressive behaviour towards people who used, visited and worked at the service. Incidents of aggression had not triggered an assessment of the risk this behaviour posed to people who used, visited and worked at the service. No plans were in place that contained information to guide staff on how to manage this behaviour if it should occur again. This lack of guidance meant staff were not equipped to manage this behaviour. For example, one of the staff members we spoke with was not aware of this person's previous aggressive behaviour at all, so did not know it was a risk that may require future management. This placed people who used, visited and worked at the service at risk of harm to their health, safety and wellbeing.

Four people's care records showed they were at high risk of falling. All four care plans stated that each of the four people needed support from staff to enable them to move safely. We saw all four people moving around the home without the staff support they required to promote their safety. All four people had fallen on occasion since October 2016. One of these people was seen to be very unsteady and an inspector intervened to enable them to access their chair in a safe manner. This person's care records showed they had fallen on six occasions since October 2016 in communal areas of the home. Five of the six falls were unwitnessed by staff. This showed this person did not always receive the support they needed from staff to help manage their risk of falling as planned.

This person had also been found by staff to have accessed or attempted to access the open stair case at the home. These incidents had not triggered an assessment of their risk of accessing and falling on the stairs and no preventative measures had been taken to manage this person's continued risk of accessing and using the stairs in an unsafe manner. This placed this person at high risk and ongoing harm to their health, safety and wellbeing.

One person who used the service had a skin wound and had been identified as being at high risk of further

skin damage. This person had a plan in place to manage this risk that stated they needed to sit on a specialist cushion and receive support to change their position every hour. The person's care records showed and we saw that this care plan was not consistently followed. For example, during breakfast and lunch, we saw that the person was not seated on their prescribed cushion as planned. A staff member told us, "There's nowhere to plug it in [in the dining room]". This person's care records showed they were not always supported to change their position every hour as planned. For example on one occasion their records showed a 13 hour 25 minute gap between receiving support to change their position. On the morning of our inspection, we saw this person wait two hours and 55 minutes before being supported to change their position as planned. This meant this person's risk of further skin damage was not being managed as planned to promote their health, safety and wellbeing.

Three people's care records contained assessments that showed they were at high risk of developing pressure damage to their skin. No plans were in place to manage and reduce the risk of skin damage for these three people. Staff told us they were not aware of any preventive measures needed to manage these people's risk of skin damage. This meant we could not be assured that action had been taken to reduce these people's risk of skin damage.

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

We found that staff were not effectively deployed to promote people's health, safety and wellbeing. We saw that staff were not present in communal areas to check and promote people's safety. For example, we saw that one person was left in the lounge for a 15 minute period on their own after other people who used the service had been supported to access the dining room. This person's care plan stated they needed staff support to move safely. This person told us, "I think they've forgotten about me". They then proceeded to access the dining room without staff support and when they entered the dining room they said, "Why am I still waiting out there?". A member of staff replied, "Have the girls not been to you?". This meant the person did not receive their planned care because staff were not available to provide this support. The person's care records also showed they had fallen on eight occasions since October 2016. This showed they were at high risk of falling again and staff had not managed this risk effectively.

We observed the lounge left unsupervised for significant periods of time during our inspection. On one occasion this was for a 20 minute period. The care records of four of the people who were seated in the lounge at this time showed they were at high risk off falling if they attempted to mobilise without staff supervision. Falls records showed there had been at least 25 falls since October 2016. At least 12 of these falls had occurred in communal areas and 10 of the falls were confirmed to have been unwitnessed by staff. This showed staff were not always present in communal areas to promote people's safety as planned.

The above evidence shows that staff were not always available 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.

People were not protected from the risk of abuse because the registered manager could not evidence that all the staff were of suitable character to work at the service. We requested to view three staff files. We looked at two staff files as the third was unavailable. We were unable to confirm that safe recruitment systems were used for one of the staff member's files we viewed. The registered manager was unable to demonstrate the staff member was of suitable character as no employment history, evidence of interview or work references were available. When checks of staffs' criminal history checks came back positive, the

registered manager was unable to demonstrate that any potential risks this outcome posed to people had been assessed and managed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the missing recruitment information was with the provider and they said they would send this to us after the inspection. We had not received this information at the time of writing this report.

Some of the staff we spoke with told us how they identified, recorded and reported potential abuse. However, two of the staff we spoke with told us they had not yet received training in safeguarding. This meant they were not aware of all the types of abuse people may be exposed to and the formal reporting procedures for this. This placed people at risk of abuse as some staff did not have the skills and understanding to identify and report potential abuse. We also identified an incident of potential abuse in one person's care records. This person had been admitted to the service from hospital with a skin wound that could have been caused from neglect. However, this had not been reported to the safeguarding team as potential abuse. The registered manager was not aware of this person's skin wound when we fed back this concern. This showed that the provider's reporting systems were ineffective and left people at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received their medicines when they needed them. Staff told us a new medicines management system had been implemented at the home. One staff member said, "It's much better than the last one. There's less risk". We saw that medicines administration records were maintained accurately, which meant people could be assured they had received their medicines as prescribed. We also saw that medicines were stored safely.

Inadequate

Is the service effective?

Our findings

At our last three inspections, we found that the requirements of the Mental Capacity Act 2005 (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 the requirements of the MCA and DoLS continued to not be consistently met.

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 2005. 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. However, we identified one person who may have been deprived of their liberty at times. This person had an alarm that alerted staff when they had left their bed so staff could monitor their whereabouts to promote their safety. This person's care records also showed that on at least four occasions this person had been prevented from leaving the home via the fire exit in order to promote their safety. This showed the staff had at times restricted this person's movements in the home. The registered manager confirmed a DoLS request had not been made. The home manager said they did not feel the person needed a DoLS because, "[Person who used the service] never tries to get to the front door". This showed a lack of understanding of DoLS as a DoLS may be required when a person who lacks capacity to consent to the restriction is under continuous supervision and control and is not free to leave. A person does not have to directly attempt to leave the home to indicate they may need a DoLS. The registered manager agreed a DoLS request was required and completed this during the inspection. This shows the registered manager was not yet consistently and proactively completing DoLS requests when needed. This was a continued breach of Regulation 13 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 effective systems were in place to gain and review people's ability to consent to their care. At this inspection, we found improvements were still needed. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Two people's care records showed they had recently had alarms placed in their bedrooms that alerted staff that they were out of their beds. Their care records contained no evidence to show they had consented to this element of their care. Their care records also contained no evidence to show that this decision had been made in their best interests with the involvement of health care professionals and their families or representatives. Neither person was able to confirm that they used this equipment when we spoke with them about it. This meant we could not be assured that these people had consented to this part of their care, or that the decision to use the alarms had been made in their best interests.

After raising this with the registered manager and home manager, the home manager asked one of the two

people to sign a consent form to say they agreed to their alarm. We had seen that this person had been confused at times throughout the day and staff we spoke with confirmed that at times this person was confused and disorientated. No mental capacity assessment had been completed to identify if the person could formally make this decision for themselves before signing the consent form. This meant we could not be assured that the requirements of the MCA were being followed.

People told us and care records showed that they were supported to see health care professionals when they were unwell. One person said, "They make sure I'm looked after when I'm not very well". However, we found that the advice of health care professionals was not always followed to promote people's health, safety and wellbeing. A physiotherapist had recommended that one person should use an alarm system that would alert staff that they had stood from their chair. This person's care records showed they had suffered five unwitnessed falls since October 2016, which meant they were at high risk of falling. No chair alarm system was in place and the registered manager told us they were not aware that this intervention had been recommended. This meant effective systems were not in place to ensure professional advice was followed. This placed this person at continued risk of harm to their health, safety and wellbeing.

Care records showed that some health monitoring was regularly completed. For example, people's weights were monitored on a monthly basis to identify and act upon any changes. However, we found that the systems in place to monitor people's diabetic needs were not effective. Some people who used the service had plans in place that stated their blood sugars needed to be regularly monitored. Care records showed that no monitoring took place for a 24 hour period because no testing strips were available. This showed that effective systems were not in place to ensure the equipment needed to monitor people's health was consistently available. This placed people at risk of harm to their health, safety and wellbeing as staff were unable to consistently monitor these people'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. 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 contained no evidence to show that any action was taken when a high reading was obtained. Staff told us they reported high readings to the home manager or registered manager, but there was no evidence to show these high readings were shared with a health care professional. 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 used to record the details of the injury. This meant that people's injuries could not be monitored for changes and the details of any injuries relating to potential abuse or neglect 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 breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that effective systems were not in place to ensure all staff had the knowledge and skills required to meet people's needs safely. Some staff told us and training records confirmed that they had not yet received any training to enable them to provide safe and effective care. For example, one staff member's records

showed they had no previous care experience and had not yet received any training despite working at the service for two months. We saw that staff who had not received training were providing care and support to people unsupervised. For example, we saw that staff who had received no training support people to access and use the toilet. This placed people at risk of harm to their health, safety and wellbeing.

We also saw one staff member assist a person to the floor as the person lost their balance. This staff member had not been trained in how to move people safely which placed them and people who used the service at risk of harm and injury. We fed back our concerns that related to the lack for training to the registered manager. They told us the home manager was responsible for organising and coordinating this training and they asked them to book this as soon as possible. The registered manager contacted us after our inspection to inform us staff had since received training in moving and handling people and safeguarding. Although this met some staff member's immediate training needs, significant training gaps still remained. For example, new staff were not aware of the requirements of the MCA and DoLS as they had not yet received this training. This meant some staff did not have the knowledge and skills to ensure they supported people in accordance with current legislation.

The above evidence shows 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 an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people told us they enjoyed the food, we saw that people did not always get the support they needed to eat. One person's care plan for eating and drinking stated they required supervision when eating. However during breakfast, we saw that staff were not consistently available to provide this supervision. As a result, we saw another person who used the service attempt to support this person to eat by placing food on their spoon for them on a number of occasions. Staff told us they were unable to consistently supervise this person at breakfast as the cook was sick. We saw that the member of care staff who was supporting people in the dining room at breakfast was also preparing and serving people's breakfast. This meant they spent time in the kitchen preparing the food, leaving the dining room unattended at times. The senior carer called an additional member of care staff to come on shift. When this additional carer arrived later in the morning this freed up a member of care staff to complete the cooks role without impacting on people's care needs. This meant at lunch time people received the support they required.

We saw that some people's lunchtime experience was not positive. People were supported to move to the dining room from 11:55am; but the first meal was not served until 13:06pm. During this time, one person who stated they were hungry was seen to wave their fork around. On occasions this person's fork came very close to other people's arms and faces, placing them at risk of injury. Staff informed us they had been told by the home manager not to start serving meals until everyone was seated in the room. The home manager stated this was because they believed mealtimes should be a 'social experience'. The desserts were not served until everyone had finished eating their main meal. Staff informed us that desserts were served in this manner because one person had a tendency to stop eating their main meal if they saw desserts were being served. This meant this approach was centred on one person's needs rather than the needs of each individual who used the service. The staff described this as 'regimented' as it meant some people were seated in the dining room for lengthy periods of time. One person who was seated in the dining room for just under two hours, expressed that they urgently needed the toilet. They were seen to be agitated about this which may have contributed to a fall they had when they attempted to stand to access the toilet. This meant this approach to mealtimes did not meet the needs of everyone who used the service.

One person told us and staff confirmed that they preferred to sit in the lounge to eat their meals. One staff member said, "If we offer [person who used the service] a choice, they choose to stay in the lounge, but [the

home manager] makes them come in". We asked the home manager about this. They said they had discussed this with the person and the person had agreed that they would eat their main meals in the dining room. However, the person's care records did not record this discussion or agreement.

The above evidence shows that people did not always receive their care in a manner that reflected their individual preferences and needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were happy with the way the care staff treated them. One person said, "The carers here are brilliant, that's why I stay". However, some people told us they felt the care had recently changed since a new manager had started to work at the home. One person described the new manager as, "Strict" and another person told us about 'new laws' that had been introduced to the home by the new manager. The 'laws' that they described were controlling, restrictive and not person centred. For example, one person said, "You've got to have a bath or a shower once a week". They told us they had not been involved in agreeing to this new routine. Staff we spoke with confirmed some new changes had been made which did restrict people at times. For example, staff confirmed that a new 'bathing regime' had been introduced that meant people had limited access to bathing. We asked the home manager about bathing at the home and they told us there were no restrictions on the amount of baths people could have. However, this information did not match the information that people, staff and records told/showed us.

We also saw care records entries that suggested the care staff were at times being restrictive rather than supportive. One person's care records contained entries that suggested their movements at night were restricted and controlling. For example, one entry stated, 'taken back to room and put into bed'. We were unable to speak to night staff to explore this further.

We observed some caring interactions between staff and people who used the service. For example, we saw one staff member crouch down beside someone to ask them if they were okay when they noticed they were distressed. The staff member chatted with the person and the person responded by smiling and laughing. However, we also observed less positive interactions which showed people did not consistently receive support in a caring manner. For example, no radiators were on in the lounge as there was a problem with the heating. A small electric heater was in the room, but it was not creating much heat. When a staff member entered the lounge we heard a person say, "Its cold isn't it". The staff member responded by saying, "I'm hot I am" and left the room. No blanket or extra clothing was offered to this person to make them more comfortable and warm. This was an uncaring approach. Three other people proceeded to tell us that they felt cold too.

We found that dignity was not consistently promoted. One person's hearing aid was whistling throughout the inspection. No staff member responded to this, to stop the hearing aid from attracting attention. Another person's care records stated they should wear an apron to protect their clothing when eating. An apron was not offered at breakfast time and the person spilled their breakfast down their clothes. Another person who used the service responded to this by saying, "They've got all food in front of them on their cardigan. It will spoil the cardigan". Staff were not present in the dining room at the time to respond to this and assist the person to clean the spilled food away.

We saw that some undignified language was used in some care records. For example, one person's care record contained the following entry, 'pee'd in another resident's commode'. This is not a dignified or professional method of recording a person's continence. Another entry showed a person had become distressed on evening and had shouted at a visitor, asking them to leave. Their care records stated,

'Explained to [person who used the service] that they were rude and can't speak to people like that'. Staff told us this person frequently became very confused and disorientated at night. The registered manager also confirmed that this person's behaviours changed in the evening due to their confusion. Telling a person who may have been confused and disorientated that they were being rude, rather than reassuring them was an uncaring approach to this person's care needs. This person's care records did not contain the information needed to guide staff in how to manage their behaviours. This meant the registered manager had not ensured staff had access to the information they needed to manage this person's behaviour in an effective, dignified manner.

We saw that people were given some choices about their care. For example, we saw people were given choices about the foods they ate at all meals. However, some choices were made for people by the staff. For example, two people told us they did not like the music that was playing loudly in the lounge area. They told us the television had been put on silent, so the music could be played. Both people told us they were not asked if they wanted to listen to the music. The music was turned off at lunch time. One person responded by saying, "Thank goodness for that".

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 visitors.

Requires Improvement

Is the service responsive?

Our findings

At our last three inspections, we found that improvements were required to ensure care was consistently provided in accordance with people's preferences and individual needs. At this inspection, we found the required improvements had not been made.

People told us they were not supported to bathe in accordance with their preferences. One person said, "It's because there's a new law here now that you have got to have a bath or shower once a week". This person added, "I'd have had one more often if I was still at home. There's not as much time to have one in here". Another person told us, "I said I'd really like a bath, but [The home manager] told me I couldn't have a bath one day. I didn't feel very clean at all". This person added, "I'd like to have a bath every other day ideally, but I'm told there are other people who need one" and, "Maybe I'm expecting too much". Staff told us recent changes had been made to the way they supported people to bathe. One staff member said, "There's a new bathing regime. We've been told to do two baths in the day and one in an evening". All the staff we spoke with about bathing told us they felt they could support people better with bathing, but they had been told to follow the new bathing plan. One person's care records also confirmed that their bathing preferences had not been met. A recent entry stated, '[Person who used the service] has requested a bath this evening' and later that day, '[Person who used the service] is unhappy that they are unable to bathe". We spoke with the home manager about this. They said people could bathe when they wished to do so. However, this did not match what people, staff and records told/showed us.

At our last inspection, we saw that parts of people's care records contained generic information, rather than information that was tailored to them. For example, generic bathing risk assessments were being used in some people's care records to guide staff how to manage the risks associated with bathing. These assessments were not tailored to each individual to show their specific risks. At this inspection, we found this continued to be the case. Risk assessments for bathing, showering, day trips and using a wheelchair were generic and didn't assess each person's individual risks for these activities. This meant this element of care had not been completed in a manner that assessed and planned for people's individual needs, risks and preferences.

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 planning and review of their care. People told us they were not involved in reviewing their care preferences and we saw that people's care plans did not always reflect their care preferences. For example, one person's bathing care plan recorded that their preference was to have a bath weekly and a shower every other day. However, this person told us that their preference was to have a bath every other day. They also told us they did not enjoy showers. This showed that the information contained in people's care records was not always accurate or up to date as the information did not always reflect people's current care preferences. This meant people continued to be at risk of receiving care that did not reflect their care preferences as they were not actively involved in the planning and review of all elements of their care.

The above evidence shows effective systems were not in place to ensure people received care that was

responsive to their individual care needs and preferences. This was an additional breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they knew how to complain about their care if needed. They told us they would tell a staff member or the registered manager. The registered manager told us they had received no formal complaints since our last inspection. However, the concerns and complaints people shared with us about some parts of their care suggested informal complaints were either not raised with the registered manager or not promptly resolved. For example, one person told us they had told the registered manager that they were unhappy with the support they received to access the bath in accordance with their preferences. They told us the registered manager had told them they could ask staff for a bath anytime. However, the person told us and care records showed their bathing preferences were still not being met. This meant that improvements were needed to ensure people's care concerns and complaints were promptly resolved.

People told us and we saw that they were supported to participate in social and leisure based activities within the home and in the community. One person said, "We have activities here. We do exercises and a few of us like playing dominoes. I'm looking forward to go going out too when the weather is better". Another person told us that they had recently enjoyed making cakes. Management records showed that the activities coordinator met with people to obtain their activity preferences and ideas. We saw that people's activity preferences were met and people were encouraged to participate in social and leisure based activities of their choosing. For example, one person told us that they liked to dry dishes after lunch as it made them feel helpful. We saw that this person was supported to do this after their lunch.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that improvements were needed to ensure the home was well-led. At this inspection, we found the required improvements had not been made. This placed people at risk of harm to their health, safety and wellbeing.

The home was managed by a registered manager and a newly appointed home manager. The registered manager told us that the home manager was also going to register with us as a manager. People and staff told us that the management changes had caused some unrest at the home. One person said, "It (the home) hasn't got the same relaxed atmosphere". A staff member said, "It's up in the air at the moment". Another staff member told us the staff group was unsettled. They said, "There is lots of bitchiness behind each other's backs. No one will say anything face to face". Some staff also told us that although they could approach the home manager with concerns, they felt they did not always treat them and people with respect. Comments included, "The way she speaks to staff and residents is not good" and, "She can be abrupt with the staff". This showed the management changes had impacted negatively on people who used the service and the staff. The registered manager told us they had identified that the home manger was 'regimental' at times and they were working with them to address this.

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 some people's care records contained incomplete/blank risk assessment documentation. These incomplete documents had been reviewed by staff on a monthly basis as being current with no changes needed. The registered manager and provider had not identified that some risks were not being assessed and planned for as required to promote people's health, safety and wellbeing. 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 plans were not in place to help staff manage people's behaviours that challenged. This meant staff did not have access to the information they needed to manage these behaviours in a safe and effective manner. As a result of this, people were at risk of receiving unsafe and inconsistent care.

The registered manager and provider had not identified that people were not always receiving their planned care. For example, one person had not consistently received their planned care to help manage their risk of developing further skin damage. We saw and care records showed that this person was not seated on their prescribed pressure relieving equipment as advised, and their care records showed they were not supported to consistently change their position as often as planned. This showed that effective systems were not in place to ensure people received their agreed care.

Safety incidents were recorded and analysed. However, no action was taken to respond to incident themes

to prevent further incidents from occurring. For example, a monthly incident analysis from November 2016 showed that a high number of people had fallen unwitnessed in communal areas. No action had been taken to ensure communal areas were effectively staffed and monitored to prevent people from continuing to fall in these areas. Following our inspection, the registered manager told us he had since deployed staff to ensure communal areas were effectively supervised. This showed that a prompt and proactive response to address risk had not been taken, as action had only been taken as a result of our inspection feedback.

We found that some of the quality checks completed by staff at the home were ineffective in driving improvements to the safety and quality of care. For example, an infection control audit in November had identified that opened food was not always labelled with an opening date or contained in insect proof containers to ensure its safety. The audit recorded that this needed to be addressed, but it did not state how it would be addressed, who by and how compliance would be monitored. We checked to see if improvements had been made to the way food was labelled and stored. We found opened, unlabelled and unwrapped food contained in the fridge. This showed effective action had not been taken to make and sustain the required improvements identified from the infection control audit.

An external consultant was working with the provider and registered manager to assess, monitor and improve quality at the home. They had devised an action plan for the registered manager and home manager to follow to address the problems they had identified. We found that some of the actions on the plan were not being achieved as planned. For example, the plan stated that the home manager needed to, 'ensure the training matrix is current at all times'. When we asked to view the training matrix we were told it was not up to date. The home manager then updated it during the inspection and shared it with us. They told us they had been working on other areas for improvement and had not managed to address this action. Not addressing this action had meant the staffs' training needs had not been monitored and met. We identified significant training gaps that placed people at risk of harm to their health, safety and wellbeing. This included people being supported to move by staff who had not had the training to enable them to do this safely and effectively.

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

We saw that the provider's rating from their last inspection at Ashview House Residential Care Home was displayed in the reception area of the home. However following our inspection, we identified that this rating was not displayed on the provider's website as required. This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.