Mrs R Elango & Mr P Elango

Ashgrove Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Ashgrove Residential Home is a residential care home providing accommodation and personal care to 21 people, at the time of the inspection.

People's experience of using this service:
• Medicines were not being managed safely. We found some people had missed their medicines and some staff competency was not assessed to identify if they were competent to manage medicines.
• Risks associated with some people's needs had not been assessed.
• There was not an effective system in place to quality assure risk assessments and medicine management to ensure shortfalls could be identified and action taken.
• Some people and relatives raised concerns with staffing levels. There were no systems in place to calculate staffing levels contingent with people's support needs. We made a recommendation in this area.
• Some staff had not completed essential training to perform their roles effectively.
• Staff felt supported by the management team.
• People were supported with their nutritional needs and had choices with meals.
• The staff worked well with external health care professionals and people were supported with their needs and accessed health services when required.
• People continued to receive care from staff who were kind and compassionate. Staff treated people with dignity and respected their privacy.
• Staff had developed positive relationships with the people they supported. They understood people's needs, preferences, and what was important to them.
• People's independence was promoted.
• Care plans were person centred and detailed people's support needs.
• More information is in our full report.

• We identified two breaches of Regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals is added to reports after any representations and appeals have been concluded.

Rating at last inspection:
• At the last inspection on 21 July 2016 the service was rated 'Good'. At this inspection, the rating for the service has reduced to 'Requires Improvement'.

Why we inspected:
• This was a planned inspection based on the rating of the last inspection.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality

care. Further inspections will be planned for future dates.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Ashgrove Residential Care Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector, an inspection manager and an expert by experience. 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:
This service is a care home for elderly people primarily with dementia and is registered to accommodate up to 26 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection:
The inspection was carried out on 6 March 2019 and was unannounced. This means the home was not aware we were coming to inspect them.

What we did:
Before the inspection, we reviewed relevant information that we had about the service including any

notifications of safeguarding or incidents affecting the safety and wellbeing of people. A notification is information about important events, which the provider is required to tell us about by law. We also checked the last inspection report.

The service completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what it does well and any improvements they plan to make.

During the inspection we spoke with the provider, registered manager, deputy manager, three care staff, three relatives and six people using the service.

We looked at the care records of five people who used the service. The management of medicines, staff training records, staff files, as well as a range of records relating to the running of the service. This included audits, premises safety checks, complaints and accident and incident records.

After the inspection, we spoke to two staff members.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Requires Improvement: 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. Regulations were not being met.

Using medicines safely:
• Medicines were not being managed safely.
• Medicines were stored in a separate room within the home. Medicines were also kept in fridges. Records showed that the temperature in the room and fridge went outside the recommended temperature ranges. There was no evidence action had been taken to remedy this meaning some medicines may not be safe to use. This meant that people may not receive the full benefits of medicines.
• We reviewed people's Medicine Administration Records (MAR) against the medicine stock and found two people on the day of the inspection had not received their medicines. This was signed as administered. One person had not received all their morning medicines.
• In another instance, we found a person had not received one of their medicines on 1 March 2019.
• This meant that people were at risk of harm due to not receiving their prescribed medicines.
• We found that some medicines such as nutritional shakes did not tally against the medicine that was recorded as administered on people's MAR. The registered manager informed us that some medicines were carried forward from the previous MAR cycle. However, this had not been recorded and therefore we could not be assured if this was a record keeping error or if people had missed their medicines.
• We found that people were given medicines as needed such as paracetamols and lactose. However, there were no protocols in place on how and when to safely administer these medicines.
• When people received their PRN (as required) medicines, records had not been kept of why the medicine was administered and the effect the medicine had on the person, to ensure they were safe or required any support.
• We were informed that senior carers administered medicines. Records showed that staff had been trained on how to manage medicines safely. However, competency assessments had not been carried out on all the staff that administered medicines to check their understanding of medicines prior to administering them. This meant that the service could not be assured that medicines were being managed safely, increasing the risk of people not receiving their medicines when they required them.

Assessing risk, safety monitoring and management:
• There was a lack of risk assessments in place to ensure people were safe at all times.
• The registered manager told us they were currently in the middle of changing the format and content of the risk assessments and care plans.
• We saw that the new risk assessments were specific to people's individual needs such as for moving and handling, falls and the environment.
• However, for some people whose risk assessments had not been updated to reflect the new format, there was a lack of robust risk assessments in place to mitigate identified risks.
• People with current and previous medical conditions such as breathing problems, skin complications,

diabetes and urinary tract infections (UTIs) lacked risk assessments. One person also used a blood thinning medicine that had not been risk assessed.
• This meant that there was a risk that people may be exposed to harm as risks were not mitigated.
• After the inspection, the registered manager confirmed that she had reviewed and updated everyone's risk assessment and this had been communicated to staff.

The above issues show the home failed to provide the proper and safe management of risks and medicines placing people at risk of potential harm. The issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risk of abuse because there were processes in place to minimise the risk of abuse and incidents.
• People and relatives told us that people were safe. A relative told us, "The staff are very caring and everything makes me feel that [person] is safe." A person told us, "It is lovely living here. I feel safe and well looked after." Another person commented, "I certainly feel safe and am not worried about anything."
• Staff told us that people were safe. A staff member told us, "People are safe."
• Staff understood their responsibilities to protect people's safety and were aware of what abuse was and who to report abuse to, internally and externally, such as the management team or CQC. A staff member told us, "Safeguarding is when a resident is being abused. If this happens, I will immediately tell the manager. I could also whistleblow, there is a number in the office we can ring. I can also let the CQC know."

Staffing and recruitment:
• Pre-employment checks such as criminal record checks, references and ID checks were carried out before employing staff.
• However, we found in two instances that staff had gaps in their employment history that had not been explored and interview notes had not been kept.
• We fed this back to the management team who informed that these were explored but not recorded. They told us they would include this as part of their interview process and ensure notes were kept on file.
• Staff had a positive approach and responded to people's needs in a timely manner when required.
• We received mixed feedback from people, relatives and staff about staffing levels.
• A relative told us, "The staff are watchful There is enough staff." A person commented, "On the whole, there is enough staff." However, another person told us, "Most times there is enough staff except if it is holidays or leave." A relative commented, "I don't think that there are enough staff."
• We asked the provider if the home completed dependency assessments to ascertain how many staff were required contingent with people's needs. We were informed that this was not completed but would be considered to ensure there were adequate numbers of staff at all times.

We recommend the home follows best practise guidance on staff deployment.

Preventing and controlling infection:
• Systems were in place to reduce the risk and spread of infection.
• The home was clean and tidy. A relative told us, "It is clean everywhere." A person commented, "No infections here and everything is kept nice."
• Staff knew how to prevent the spread of infection and had received training.

Learning lessons when things go wrong:
• Accidents and incidents were recorded and analysed for themes and patterns to consider if lessons could be learnt and these were shared with staff.

• The registered manager gave us an example of how they identified a person at risk of falls through incidents. As a result, they created a comprehensive action plan and risk assessment, which involved working with health professionals. From this, the risk of the person falling was minimised.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience:
• People and relatives told us that staff were suitably skilled to support people. A person told us, "I am well looked after. The staff do a very good job." Another person commented, "I can't believe how good the carers are. I didn't expect it. I am amazed on how good it is." A relative told us, "The staff do a good job."
• Staff told us that they were happy with the training they received. A staff member told us, "Training in general is helpful."
• Records showed that some staff had not completed training on safeguarding, health and safety, infection control and on dementia awareness. There were also gaps in training for a night staff member, who had not completed training on infection control and the Mental Capacity Act 2005.
• We discussed this with the deputy manager who informed that these training needs had been identified and staff were currently working towards completing them.
• Staff had not received supervision regularly to identify training needs and support them when required. Records showed that most staff had last received supervision in February 2018.
• The registered manager informed us that she had begun doing supervisions, which included observation supervisions and planned to carry these out shortly.
• We saw a supervision matrix was in place that scheduled when supervisions would be carried out.
• Staff felt supported. A staff member told us, "I am supported." An agency staff member told us, "[Registered manager] is good. She is helpful."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Pre-admission assessments had been carried out to identify people's backgrounds, health conditions and support needs to determine if the service was able to support them.
• The service assessed people's needs and choices through reviews. Where changes had been identified, this was then reflected on the care plan.
• This meant that people's needs and choices were being assessed to achieve effective outcomes for their care.

Supporting people to eat and drink enough to maintain a balanced diet:
• People were offered choices for their meals and liked the food. A person told us, "I am perfectly happy with the food." Another person commented, "I get a choice of meals." A relative told us, "[Person] does like the food."
• We observed staff offer people choices and engaged with people during meal times. They were supporting people when needed and asking them if they enjoyed their meal.
• People were offered two meal choices and had choices if they did not prefer anything on the menu. We

observed one person did not like the meal they initially chose and were offered another choice.
• We observed that staff closely monitored the amounts people ate and drank.
• People's weight was monitored regularly and if there were concerns then they were referred to a health professional.

Supporting people to live healthier lives, access healthcare services and support:
• People had access to the healthcare services they required, such as GP, dentists and hospitals.
• Staff were knowledgeable about people's healthcare needs, they knew how to recognise when a person was unwell and even when the person had difficulty communicating this.
• Staff requested healthcare support when this was needed and followed the advice given.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• People's capacity to make decisions was assessed and best interest decisions were made with the involvement of appropriate people such as relatives and professionals.
• The MCA and associated Deprivation of Liberty Safeguards (DoLs) were applied in the least restrictive way and correctly recorded.
• Records showed that there were seven authorisations in place and systems were in place to ensure applications or assessments were carried out when DoLs authorisations expired.
• Staff requested people's consent before carrying out tasks. We observed staff asked people if they consented to speaking with us.
• A staff member told us, "We always ask for consent like if we have to take them to toilet, we will ask beforehand."

Adapting service, design, decoration to meet people's needs:
• The premises and environment met the needs of people who used the service and were accessible.
• There was two communal area's and a dining area. There was a garden that was maintained if people wanted to go outside.
• We observed people's rooms were decorated with their preferences. However, there was a lack of signage around the home to assist people to get around the home.
• We discussed this with the registered manager. After the inspection, we were shown photo that this was implemented.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• People and relatives told us staff were caring. A person told us, "The staff are 100% caring, I feel well cared for." Another person commented, "I am treated kindly and with respect. Nothing upsets me." A relative told us, "I think [person] is treated very well."
• We observed relationships between staff and people were friendly and positive. Staff spoke with people in a kind manner and their approach was positive
• People appeared ready, dressed and comfortable at the home.
• People were protected from discrimination within the service. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against because of their race, gender, age and sexual status and all people were treated equally.
• Staff said they had time to spend with people so that care and support could be provided in a meaningful way, by listening to people and involving them.

Supporting people to express their views and be involved in making decisions about their care:
• People's families were encouraged to be involved in making decisions about care and support where this was appropriate. A relative told us, "I have been involved with decisions." "A person told us, "I am fairly independent, so I make my own decisions about the care that I need."
• We saw staff respected people's choices and acted on their requests and decisions. A person told us, "I am given choices."

Respecting and promoting people's privacy, dignity and independence:
• People's privacy and dignity was respected. We saw that staff knocked on people's doors before entering and addressed people in a kind and caring way. A person told us, "The carers knock and ask permission to come in."
• We saw staff were sensitive and discreet when supporting people. A relative told us, "My relative is treated with dignity and respect."
• Staff understood that personal information should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting their dignity.
• People and relatives told us that people were encouraged to be independent.
• We saw people were independent with eating meals with staff nearby to support if needed and a person helped tidy the dining room after lunch. People mobilised independently and went to their rooms and other parts of the home when they wanted to.
• A person told us, "I am well looked after. I try to be independent but they help me if necessary." Another person told us, "I am allowed to be as independent as I like, they are brilliant."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• Care plans detailed people's support needs. Care plans included information on how to support people with personal care, nutrition and continence. Information on one care plan included, when hoisting a person, the person may pull the hoist or try to escape so staff should be vigilant and reassure the person.
• A staff member told us, "Care plans are helpful." A relative told us, "[Person] is now more mobile than before. Having spent most of the time in bed [previous home], the staff here have got [person] walking with a frame."
• We saw one comment from a relative, which showed the positive impact the home had on a person. The comment included, "[Person] has received excellent care in the short term. [Person] has been at Ashgrove. [Person] was underweight and very unhappy. The change is unbelievable. [Person] has gained weight and personal care has been dealt with. [Person] is very happy."
• There was a daily log sheet and handover book, which recorded information about people's daily routines, behaviours and daily activities in most cases. Staff told us that the information was used to communicate with each other between shifts. A person told us, "I think there is a good team. All work together." This meant that people received continuity of care.
• People took part in regular activities of their choice.
• There was an activities timetable displayed in the communal area and photos of people taking part in activities.
• One person told us, "I enjoy the music and I do painting." Another person commented, "I do games, exercises and gardening." A relative told us, "I know of the activities, cake icing, balloon bashing and music. The staff are brilliant, nothing is too much trouble."
• We observed that staff spent time with people watching TV and playing games.
• We observed a singing session taking place where people sang and danced, which they enjoyed.
• People received information in accessible formats.
• From August 2016 onwards, all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss.
• The home was complying with the Accessible Information Standard.
• Care plans detailed people's communication ability and how to communicate with people effectively.
• We observed communication between people and staff was positive. A relative told us, "Staff are very good at communicating, has hearing aids. Batteries are kept available by home and me as they would be lost without them."

Improving care quality in response to complaints or concerns:
• All complaints were recorded along with the outcome of the investigation and action taken.

• People and relatives were aware of how to make complaints. A relative told us, "If I had any concerns and complaints, I would start off with the staff or manager."
• A number of compliments had been received.
• Comments included, "Thank you for all the care you gave [person]" and "Thank you very much for today, I am going away feeling very positive."

End of life care and support:
• Where possible, end of life care had been discussed with people.
• These included people's preferences with end of life care and their preferred burial.
• Do Not Attempt Resuscitation forms were in place in people's care plans. These were also audited by the registered manager to ensure the information was accurate and signed by relevant health professionals.

Requires Improvement

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.

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:
• There was not an effective quality assurance system in place to identify shortfalls and act on them to ensure people were safe:
• Audits had been carried out on medicine management, environment, accidents, incidents and deprivation of liberty. There was a weekly and monthly medicines audits.
• However, the last medicines audit was carried out on 21 February 2019 and no further audits had been carried out that may have identified the shortfalls we found with medicine management.
• Audits had not been carried out on care plans that may have identified the shortfalls we found in these areas in regard to risk assessments.
• This meant that there was a risk people may not receive high quality care to ensure they were safe at all times.
• After the inspection, the registered manager sent us an action plan outlining the actions they have taken to strengthen audit processes.

The above issues show the home failed to ensure robust audit systems were in place to identify shortfalls and act on them to ensure people were safe at all times. The issues related to a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• Quality monitoring materials such as surveys were sent to people, staff and relatives.
• The results were positive and had been analysed to identify areas for improvements. Comments from people and relatives included, "I like all the staff here" and "I don't think you need to improve on anything. The staff are always so helpful. We are entirely satisfied with the care."
• Meetings were held to obtain people's and relative's thoughts on the running of the home and acting on their feedback where possible, to create a cycle of continuous improvement.
• After the meeting, people were able to have a one to one discussion with a member of the management team. Comments from one person included, "Meal was brilliant, really lovely" and "Staff wonderful."
• People told us they liked living at the home. A person told us, "It is quite nice living here." Another person commented, "I have been here about six months, it is a pleasure living here." A third person commented, "I am amazed at how nice it is here."
• People and relatives told us the home was well-led. A person told us, "If I want anything, I just go to the

manager and it is sorted." Another person told us, "There is nothing bad at all about the home. I know the manager, she is competent." A relative commented, "[Deputy manager] and the staff are good. Nothing is too much trouble. There is nothing the home could do better."
• Staff meetings were held.
• The meetings kept staff updated with any changes in the service and allowed them to discuss any issues or areas for improvement as a team to ensure people received high quality support and care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Staff told us the service was well led. One staff member told us, "[Registered manager] is approachable, very helpful and supportive." Another staff member commented, "[Registered manager] is a good manager. She is supportive and friendly."
• There was a clear management structure and staff were clear about their roles and were passionate in ensuring people received good care.
• Staff felt they could approach the management team with concerns and this would be dealt with.
• Staff told us that they enjoyed working at the home. A staff member told us, "I like working here." Another staff member told us, "I have been working here a long time. I have no regrets working here."

Working in partnership with others:
• Staff worked in partnership with other agencies.
• Information was shared appropriately so that people got the support they required from other agencies and staff followed any professional guidance provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(a)(b). The registered provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines Regulation 12(1)(2)(g).

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was not robustly assessing, monitoring, improving the quality and safety of the service users and mitigating the risks relating to the health, safety and welfare of service user's who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b). The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c).

The enforcement action we took:

Warning Notice