Care Quality Commission

Ashview House Limited

Ashview

Inspection report

River View High Road
Vange Basildon
Essex
SS16 4TR

Tel: 01268583043

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15 January 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Ashview is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Ashview accommodates up to eight people who may have a learning disability, in one adapted building. At the time of our inspection, five people were using the service.

This inspection took place on 15 January 2018. The inspection was unannounced, this meant the staff and provider did not know we would be visiting.

At the last inspection on 7 October 2015, the service was rated 'Good'. At this inspection we found that the service remained good.

A registered manager was in post. 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 2008 and associated Regulations about how the service is run.

We found that improvements needed to be made to the outdoor area to ensure that this was accessible, and that the décor within the service would benefit from being updated. We have recommended that the provider updates the décor and external areas of the service, and ensures that people are involved with these decisions.

People spoke positively about the service and told us they were listened to by staff that were kind and caring towards them. People told us that they felt safe and staff understood what abuse was. They knew what steps they should take to protect people and keep them safe. Risks to people's daily life had been assessed and contained detailed information to ensure people were kept safe from harm.

Checks were undertaken on staff suitability for the role and there were sufficient numbers of staff available to meet people's needs in a safe way. However, we did find that when staff did not turn up to work that this had an impact on people and staff. We have made a recommendation to increase and maintain consistent staffing levels.

There were adequate systems in place for the safe administration of medication and people received their medicines as prescribed.

Staff received an induction to prepare them for their role and additional training was provided to support their learning and development. The manager assessed staff's competency to ensure that staff had understood the training and were able to put it into practice.

Staff had understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards

(DoLS).

People who lived in the home were positive about the quality of the food and our observations were that people enjoyed their meals. People had meaningful activities offered to them but when staff did not turn up to work this prevented them from going out from time to time.

Care plans were written holistically and reflected people's needs. Information about people's health and support needs were available to people in a way that they understood. Assistive technology enabled people to speak with staff and share their views.

No complaints about the service had been received over the last 12 month, but systems were in place so that if a complaint was made, this would be appropriately investigated.

There were systems in place to drive improvement and audits were carried out on a regular basis, which looked at the quality of the service people received. The registered manager had a clear oversight of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? This service remains good.	**Good**
Is the service effective? This service remains good.	**Good**
Is the service caring? This service remains good.	**Good**
Is the service responsive? This service remains good.	**Good**
Is the service well-led? This service remains good.	**Good**

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Ashview

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 is 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.

This comprehensive inspection took place 15 January 2018. It was unannounced and was carried out by one inspector.

We reviewed all the information we had available about the service, including notifications sent to us by the provider. A notification is information about important events, which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection. We also reviewed the information the provider had given us in their Provider Information Confirmation (PIC). This form asks the provider to give some key information about the service, what the service does well, and the improvements they plan to make.

During the inspection, we spoke with two people that used the service, one relative, four staff, and the registered manager. We also spoke with one visiting health professional and obtained feedback from the local GP.

We used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed how staff interacted with people who lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

We reviewed three people's care records, two staff recruitment records, medication charts, staffing rotas and records, which related to how the service monitored staffing levels and the quality of the service. We also looked at information, which related to the management of the service such as health and safety records, quality-monitoring audits and complaints.

Good

Is the service safe?

Our findings

On the day of the inspection, there were enough staff to meet people's needs in a safe way. However, when we spoke with people and staff and looked at the rota's we found that staffing levels were not always consistently maintained. When staff did not turn up to work this had an impact on people.

One person told us, "Staff do not stay and don't always turn up." We looked at rotas and found that sometimes the service was running without optimum staffing levels. The registered manager explained that the service's biggest challenge was recruiting and retaining good quality staff. They explained that when staff did not turn up to work, that agency staff could not always be arranged at the last minute. The deputy manager was then used to deliver care to people.

We looked at minutes from recent staff meetings and found that inconsistent staffing levels had been reported as a problem. One relative explained, "It's a shame there are not more staff. It is not that it is unsafe, but it does have an impact. For example, they haven't been able to go bowling."

We recommend that the registered manager look at ways that staffing levels can be increased and maintained.

Staff recruitment files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS). This scheme enables the provider to check that candidates are suitable for employment.

Systems were in place to safeguard people from abuse and discrimination. Staff knew how to keep people safe, understood their roles and responsibilities to respond to, and report any incidents or allegations of abuse.

There had been no reported accidents or incidents in the last six months, but systems were in place to monitor accidents, incidents and near misses, which included ways to respond to safety issues and to look at ways lessons could be learned when things had gone wrong.

Risks to people were assessed and management plans were in place to reduce the likelihood of harm. For example, detailed information and guidance was available for staff so that they could understand how to meet people's day to day needs safely. Equipment was available to staff and was in good working condition.

People's medicines were stored and dispensed correctly. People received their medicines in the correct way and at the right time. Advice was available for staff when people required pro re nata (PRN) medicines. PRN means medicines prescribed to be taken when it is needed. Staff were trained and competent. The registered manager regularly audited medicines to make sure that people were receiving their medicines in the correct way.

The service was clean and audits and checks were carried out to maintain the cleanliness of the service. Staff were observed following good infection control practices to help reduce the spread of infection, including regular hand washing and wearing aprons to protect their clothes.

All areas of the service were subject to daily cleaning and deep cleaning as required. Infection control policies and audits were in place to help ensure standards were maintained. The registered manager arranged for the maintenance of equipment and held certificates to demonstrate this had been done. These included hoists, fire equipment and electrical appliances. Plans were in place in case of an emergency, for example evacuation procedures in the event of a fire.

Good

Is the service effective?

Our findings

People told us their needs were met. One person said, "The staff are okay and help you to do what you need them to." We observed staff providing the care and support when people wanted it.

Some aspects of the environment needed to be improved. For example, some of the walls and woodwork needed painting and the path accessing the outdoor area to the garden was uneven. The registered manager and staff had raised this as an area that needed improvement on a number of occasions, but the funds from head office had not been provided so that they could carry out this work.

We recommend that that the remedial work to the environment is carried out so that people can have safe access to the garden area. We recommend that the provider make improvements to the décor of the service, taking into account people's choice about the way in which they would like this to be done.

Policies were in place in relation to protected characteristics under the Equality Act, and the provider looked at ways they could make information accessible for everyone who needed this to make decisions about their care and support. For example, records clearly showed when someone required additional support to make sure they could understand their personal information. For example, information was presented using pictures and symbols.

Care plans, policies and service user guides had been produced in a format so that people understood them and were able to make informed decisions about their care and support options. When somebody needed assistance to speak in a way that others could understand, assistive technology was used. One person used technology to talk with us and tell us about their experience of living at the service.

People were cared for by staff who had received the training required to meet people's needs. We viewed the training records for all staff. These identified when staff had received training in specific areas and when they were next due to receive an update. All staff received core training which, among others, included; first aid, infection control, fire safety, food hygiene, equality and diversity, administration of medicines and safeguarding vulnerable adults. The provider also offered training suited to the needs of the people living at the service, such as, how to administer buccal midazolam. This medicine is administered in a specific way and staff need specific training to be confident to administer this type of medicine correctly. One staff member said, "The training here is good. There is lots of training to do, and I feel confident in my role."

Staff confirmed that when they commenced employment at the service they had received an induction. Newly appointed staff completed induction training, including the completion of the Care Certificate. The Care Certificate was introduced in April 2015 for all new staff working in care and is a nationally recognised qualification.

Staff received support to carry out their roles effectively. The service had a programme of staff supervision in place. Supervision meetings are one to one meetings a staff member has with their supervisor. Staff members told us they received supervision and records showed that supervisions were held regularly.

People chose what they wanted to eat and were involved with choosing their menus and going shopping for the food items. We saw people had access to a variety of drinks throughout the day. We saw staff being very patient and encouraging people if they needed additional support. Meal times were flexible and we saw people choosing when and where they wanted to eat and drink. Some people sat together at tables, others chose to stay in their seat. People told us that the food was good.

Staff were knowledgeable regarding the risks posed to people who needed additional support to eat and drink in a safe way. These risks were monitored and well managed. Some people needed their food to be textured so that they could eat in a safe way and not choke. Detailed guidance was available and staff could clearly explain in detail how to support the person to eat in a safe way. People's weights were regularly monitored and information from speech and language teams (SaLT) was clearly recorded.

People told us their day to day health needs were being met and they had access to healthcare professionals according to their specific needs. The provider worked well with other health services to make sure that people could access the care, support and medical treatment they required. Hospital passports were in place, which enabled staff to access people's information quickly if this was needed. People had health plans in place that described how they could maintain a healthy lifestyle.

People were registered with the local GP surgery and staff assisted them to make and attend appointments when needed. One health professional said, "The staff are supportive. They bring people to hydrotherapy sessions and they are always on time. They are supportive, encouraging and caring. They are open to new suggestions and my recommendations are carried out to the 't'." We also received positive written feedback from the local GP surgery.

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 when this is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had policies and procedures in place and staff had received training on the MCA and DoLS. Care plans contained an assessment of people's capacity to make specific decisions. These were individual to the person and identified when the person was most likely to be able to make a decision and how it should be explained to them to maximise their understanding.

Some people had been assessed as not having the capacity to consent to their care arrangements. They were also subject to continual supervision to ensure they were safe and their needs met. The manager and staff had recognised this amounted to a deprivation of their liberty and had submitted applications to the appropriate authorities.

Staff actively encouraged people to make their own day to day choices and decisions. We saw they asked for people's consent before providing care and support, gave them options to determine what they wanted to do, and, respected their decision if they changed their mind. Care records gave clear information to staff

about areas where people could make their own decisions and how people could be supported to make those decisions. Records showed that when decisions were made they were in the best interests of the person.

Good

Is the service caring?

Our findings

People were happy with their care and told us that staff were kind and caring. One person said, "I like [staff member] they are the best." One relative told us, "The staff have a good rapport with people here and they are excellent. They work very, very hard."

During the inspection, at times, staff were busy but we observed staff interactions with people were positive. There was a calm and relaxed atmosphere and people had good relationships with staff. Staff spoke in a caring, warm and respectful manner. Staff looked at ways they could remove barriers if people had difficulty communicating with others. They used assistive technology to assist this process. For example, one person used a device that constructed sentences. This enabled the person to have conversations.

Staff spoke with people by kneeling or sitting next to them and they took the time to listen to what people were saying. Staff could understand what clues people were giving when they were anxious and looked at ways to comfort and reassure them. For example, one person thought they had lost their car keys and became anxious. The staff member quickly went and found this persons keys.

People were encouraged to make choices, and their independence was encouraged according to their abilities. We saw that staff knocked on bathroom doors and waited for a response before entering. We saw people being spoken to discreetly about personal care issues. For example helping people to go to the toilet so as not to cause any embarrassment.

Staff did not hesitate to deliver care in an intimate way when people requested this, and people felt comfortable asking for help. For example, we observed one person ask a staff member if they could help them blow their nose, but after the staff member had helped them this person was still uncomfortable. They told the staff member they had an itchy nose. Using a fresh tissue, the staff member helped to itch this person's nose and as they did they said, "Back and forth, back and forth all done." This person smiled and made a satisfied noise, and appeared to be much more comfortable.

People were supported to maintain relationships with family and friends. Visitors and family members told us they were always welcome and were able to visit at any time. People's care records contained contact details and arrangements. People who did not have any direct involvement from family members were supported to access advocacy services. We found one example of when a person had an advocate involved in the past. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to, have their voice heard on issues that are important to them.

Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments. Doors were always kept closed when people were being supported with personal care and staff knocked and waited for a response before entering a person's room.

People's care records included an assessment of their needs in relation to equality and diversity. The provider looked at ways to meet people's cultural and religious needs. Staff could explain that they

understood the importance of maintaining people's privacy and human rights.

Good

Is the service responsive?

Our findings

The service was flexible and responded to people's needs. Each person had detailed care plans in place that identified how their assessed needs were to be met. These included information on their background, hobbies and interests and likes and dislikes. When people had a specific communication need this had been considered and suitable arrangements put in place.

Care plans included detailed assessments, which took into account people's physical, mental, emotional and social needs. Care plans had been reviewed regularly or when people's needs changed. Relevant health and social care professionals were involved when required and professionals told us their advice was listened to and acted on by staff.

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals. Any changes to people's care was discussed at handover meetings. Staff told us this was important so they were aware of any changes to people's needs. Handover meetings enable staff to share important information during shift changes.

Staff supported people in activities and they could access the community to maintain a fulfilled day-to-day life. Sometimes, because staff had called in sick, this had affected people being able to access the community when they would like. We have made a recommendation about this in key question, 'is the service safe?' section of the report.

Meetings were held with people, staff and relatives to seek their views regarding their care and support. Minutes of meetings were produced, including formats using pictures and symbols so that people could understand the content.

People and their relatives said they felt able to raise any concerns they had with the registered manager or staff. There had not been any complaints regarding the service in the last 12 months. Systems were in place to deal with any future complaints appropriately. An easy read version of the complaints procedure was on display. We noted a number of compliments about the service had been received.

Where appropriate, the information about people's preferences at the end of their life was recorded. The registered manager had links with the local hospice when people required end of life care. When people had come to the end of their life, they had been given a choice about where they wanted to die. The registered manager considered the person's preferences and choice and involved palliative care professionals in a timely way.
Support was offered to staff and people in the service to commemorate people's lives and to help them come to terms with the death. When it was appropriate, and the person had agreed a 'do not attempt resuscitation' (DNAR) was in place. A DNAR is a way of recording the decision a person, or others had made on their behalf that they were not to be resuscitated in the event of a sudden cardiac collapse.

Good

Is the service well-led?

Our findings

The registered manager had worked at the service for a number of years. They were knowledgeable about the needs of people who used the service. Staff spoke positively about the registered manager and described them as open and approachable. One relative said, "The registered manager was good, and all the staff worked very hard."

The registered manager was experienced and understood the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and understood when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service.

Quality assurance systems were in place and looked at what could be improved. The registered manager completed audits that looked at a number of key areas. This had identified the improvements needed to staffing and the environment. The registered manager had reported this to head office and told us they were waiting for the resources to be allocated to be able to make the improvements required. Following a recent survey, positive feedback was noted.

The management structure was clear and understood by staff. An experienced deputy assisted the registered manager with the running of the service. Staff told us they were able to raise any concerns regarding poor practice and were confident these would be addressed. The registered manager told us that their main challenge had been to recruit sufficient numbers of staff to enable people to receive consistent care.

Systems were in place to ensure that if they had occurred, accidents, incidents, complaints and safeguarding would be appropriately dealt with. The provider had made key links with organisations and looked at ways they would keep informed of best practice by working with the local authority. Staff meetings were held regularly. We looked at the minutes of previous meetings and saw a range of areas were discussed. These included, individual care and support arrangements and staff related issues. Staff told us they found these meetings helpful. Records of these meetings included action points, which were monitored by the registered manager to ensure they were completed.

A copy of the most recent report from CQC was on display at the service and accessible through the provider's website. This meant the public could easily access the most current assessment of the provider's performance.