HC-One Limited

Ashton View Nursing Home

Inspection report

Wigan Road
Aston-in-Makerfield
Wigan
Greater Manchester
WN4 9BJ

Tel: 01942722988
Website: www.hc-one.co.uk/homes/ashton-view/

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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?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

This comprehensive inspection was unannounced and took place on 10 May 2017.

At our inspection on 22 October 2015, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in regards to safe care and treatment and governance.

The home was rated as requires improvement overall and in the key lines of enquiry (KLOEs) for; safe, effective and well-led. The home was rated as good in caring and responsive.

At this inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regards to regulation 12; safe care and treatment (two parts), regulation 13; safeguarding service users from abuse and improper treatment (two parts), regulation 14; meeting nutritional and hydration needs and regulation 17; governance (two parts). We also made three recommendations in relation to reviewing the dependency tool used to calculate staffing, the environment and activities. We served a warning notice in regards to regulation 17; good governance (two parts) and received an action plan from the registered provider detailing how the areas of concern would be addressed to ensure the home was compliant with the regulations.

Ashton View is in Ashton-in-Makerfield and is part of HC-One. The home provides residential and nursing care as well as care for people living with dementia. The home provides single occupancy rooms, across three units, which are known internally as Evans (general nursing), Gerard (providing nursing care for people living with dementia) and Pilling (residential). At the time of the inspection there were 53 people living at the home.

At the time of the inspection, there was no registered manager in post. The home's registered manager had left in April 2017 and a regional support manager from HC-one was providing daily oversight and management whilst recruitment was underway for a new registered manager. 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.

The regional support manager was on leave when we undertook the inspection and management oversight was being provided by another manager from within HC-One. The interim manager had only been post for two days prior to our visit and acknowledged they were unable to answer some of our historical enquiries as they had not been present at the home during that period.

People who used the service and the majority of relatives told us they felt the service was safe. Staff recruitment was robust with appropriate checks undertaken before staff started working at the home.

We received a mixed response from people living at the home, staff and visiting relatives with regards to staffing levels at the home. Whilst a formal dependency tool was used to determine staffing numbers and staff said they felt people's care needs were not compromised as a result of current staff numbers, they reported feeling rushed and unable to spend time with people. We have made a recommendation with regards to staffing levels in the detailed findings of this report.

We found staff received online safeguarding training but staff indicated they would benefit from face to face training in this area. We found two specific incidents which involved a person living at the home that had not been reported to the local authority for investigation.

We identified issues with the management of stock levels and re-ordering of medicines, which meant people had missed doses of medicine until new supplies arrived. We also identified some issues with the recording of as required medicines (PRN) to establish a clinical picture.

The service had a training matrix to monitor the training requirements of staff. Staff received appropriate training, supervision and appraisal to support them in their role.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Mental Capacity assessments had not been conducted when they had been required. The provider had no oversight as we found granted authorisations which had expired and referrals had not been made timely. This meant that people were being deprived of their liberty unlawfully.

People were not always protected from the risk of losing weight and we identified two people who had continued to lose weight and their Malnutrition Universal Scoring Tool (MUST) score indicated a referral to the dietician for assessment was required. We found this had not been done. There were no food and fluid records which meant we could not ascertain people's calorie intake and whether snacks had been offered. These measures could have helped peoples weight to increase over time.

People were complimentary about the staff and support they received. People's privacy and dignity was maintained and their independence was encouraged. People told us that staff were respectful of their wishes.

People's care plans were reflective of their preferences and needs and reviewed regularly in conjunction with them and their relatives.

There were systems in place to seek feedback from people living at the home and their relatives. This included residents/relatives meetings and satisfaction surveys. The results of these were then analysed, with action plans put in place to drive improvement.

There were systems in place to investigate and respond to complaints appropriately. The people we spoke with said they would speak with staff or the manager if they were unhappy with the service they received.

The systems in place to monitor the quality of service being provided required strengthening. There were comprehensive audits undertaken which had not identified the areas of concern that we highlighted during the inspection.

During feedback, we found the management to be honest and transparent and they acknowledged that further progress was required. The management demonstrated a commitment to address the issues identified and sent an action plan following the inspection detailing how the areas identified would be

addressed in a planned and structured way.

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

Not all aspects of the service were safe.

Medicines were stored, handled and administered safely by staff who had received training but we identified issues with the timely re-ordering of some medicines and the recording of PRN.

A safeguarding issue had arisen and had not been handled appropriately or referred to the local authority for investigation.

Risk assessments were in place but care plans had not been updated timely to identify control measures to mitigate risks.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The provider could not demonstrate they were consistently meeting people's nutritional needs and records required strengthening in this area.

Mental capacity and restrictive screening assessments had not been carried out. Deprivation of Liberty Safeguards had been authorised but subsequently expired. People were being deprived of their liberty unlawfully.

Staff had regular supervisions and completed training that was effective and relevant to their roles.

Is the service caring?

Good

The service was caring.

The service was caring.

People and staff spoke fondly of each other and we saw people were treated with kindness, compassion and respect.

People's dignity was maintained and their independence promoted.

People's care was planned in conjunction with them and their

preferences were adhered to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a comprehensive initial assessment undertaken with people and care plans were formulated taking in to account people's preferences and reviewed timely.

The arrangements for social activities required strengthening and aligning with people's preferences.

A complaints procedure was in place and people knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not consistently well-led

We found the regulations were not being met and the provider had failed to improve the overall rating of the home.

Systems for audit & quality assurance required strengthening in order to identify failings.

People, their relatives and the staff spoke favourably of the new management. They all confirmed there had been improvements made since the regional support manager started at the home.

Ashton View Nursing 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 checked 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.

We carried out this unannounced inspection on Wednesday 10 May 2017. This meant the provider did not know we would be visiting the home on this day. The inspection was undertaken by three adult social care inspectors from the Care Quality Commission (CQC).

As part of our inspection planning we reviewed all the information we held about the home. This included previous inspection reports and any notifications sent to us by the home including safeguarding incidents, expected/unexpected deaths and serious injuries. We also reviewed the PIR. This is a document where the provider can state any good practice within their service and how they ensure their service is safe, effective, caring, responsive and well-led. We liaised with the local authority and local commissioning teams.

At the time of this inspection there were 53 people living at Ashton View Nursing Home. The home provides single occupancy rooms, across three floors. The ground floor is Evans (general nursing), first floor is Gerard (providing nursing care for people with dementia) and the third floor is Pilling (residential).

During the day we spoke with a HC-One manager who was providing interim support to the home whilst the regional support manager was on leave. We also spoke with the home administrator, two nurses, five care staff, the activities coordinator, the chef, seven people living at the home, three relative's and a visiting healthcare professional.

As part of the inspection, we looked around the building and viewed records relating to the running of the home and people's care. This included eight care plans, eight staff personnel files and 12 medication administration records (MAR).

Throughout the inspection, we spoke with people in communal areas and their rooms. We observed how staff provided care and support to people living at the home. We also observed breakfast and lunch being

served on each floor to see how people were supported to eat and drink.

Requires Improvement

Is the service safe?

Our findings

The people we spoke with as part of the inspection consistently told us they felt safe living at the home. One person told us; "I feel safe. Everybody knows everybody." A second person said; "Yes absolutely, I feel safe, no worries at all, I never have any problems. Everything is just grand." A third person said; "I feel safe, no worries." A fourth person said; "I feel safe and I like that they give me my own space."

A relative told us; "[My relative] is very safe living here." A second relative said; "I am here every day. The care is smashing, loving, caring, considerate and very safe. I can assure you of that."

We looked at the systems in place to safeguard people from abuse and improper treatment. There was a safeguarding policy in place and the training matrix indicated that 86% of staff were up to date in safeguarding training. The remaining staff had dates identified for completion. We received a mixed response from staff regarding the quality of the safeguarding training received and some of the staff we spoke with indicated that the online training was basic and felt that they would benefit from classroom based training in this area. A staff member said; "I think we could train more in this, not sure when I last did it. We do this via e-learning which is not the best method for me; I prefer face to face, practical training." A second staff member said; "Safeguarding covers all sorts of things in relation to abuse, giving someone the wrong tablets and violence, even if it is a resident hitting another resident." A third member of staff said; "The online training gives us flexibility to complete the training but it is basic. I know the residents, so I'd recognise safeguarding issues. If there were indicators of verbal, physical or sexual abuse, we'd know. We support people's personal care so we'd see bruises but we'd notice if a person's behaviour changed." A fourth staff member said; "It's about protecting the vulnerable." A fifth told us; "I know the signs of abuse, if I saw anything I would go to the nurse, the manager or above them if needed."

Whilst undertaking the inspection, we were made aware of two separate incidents that had occurred involving a person living at the home. The first incident involved the person falling forwards on to their face from a reclining chair. On the second occasion, the person had leaned forward and fallen out of the wheelchair landing on their face and sustained severe bruising to their face and upper chest. The paramedics attended the home but were happy for the person to remain in the care of the home. We looked at both incidents individually and found the circumstance leading to each incident were not connected and therefore, could not be foreseen or prevented. This meant the person had not been exposed to the significant risk of avoidable harm. We also found the provider had informed the person's family and sought the required medical assistance. However, we found the provider had not reported these incidents as a safeguarding referral to the Local Authority. We spoke to the manager and enquired why this had not occurred but they were not in post at the time of the incidents. They assured us that they would look in to the matter and made the safeguarding referrals during the inspection.

This is a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding people from abuse and improper treatment. We found the provider had not implemented and operated systems effectively to prevent abuse.

Since the last fall, this person had been cared for in bed, which the staff said was due to the person's levels of agitation and risk of falls when seated. This meant the person had not been exposed to further risks. However, we found the health and safety concerns had not been discussed with the person's family, GP or included in the person's treatment plans and there was no time frame specified in the care plans for this restriction to be imposed. We saw no specific risk assessment or care plan around falls management following these incidents or information captured to highlight the risks of the person falling to mitigate the risk of this occurring again.

We saw in the care records we looked at areas of risk assessed included; falls, bed rails, nutrition, choking, continence, tissue viability and fire. All expected risk assessments were in place but as identified in regards to the person that had experienced two falls in quick succession, care plans had not been developed timely to identify how the risk would be managed.

This is a breach of Regulation 12 2 (b) as the provider was not doing all that was reasonably practicable to mitigate the risks.

We looked at 12 medication administration records (MAR) to ascertain whether the management of medicines was safe in the home and found that systems and processes varied across the three units.

When completing checks of people's medicines, we saw stock balance checks and re-ordering of medication processes were not working effectively. One person had run out of a particular medicine, Trazodone, on two occasions within the last six weeks. The person had been without this medicine between the 23 and 25 April 2017 and missed six doses and again on the 08 May 2017 and missed three doses. Although we found the person had suffered no ill effects from missing the medication, this was not good practice.

We also found the provider could not demonstrate medicines were consistently given as per prescriber's recommendations. Some medicines that needed to be given before food, such as medicines to reduce gastric acid, staff acknowledged had been given with other medicines and on occasion following people having eaten their meal.

This is a breach of Regulation 12 (2) (f) as the provider had not ensured people's medicines were available in the necessary quantities at all times to prevent the risks associated with medicines that are not administered as prescribed.

We saw 'as required' (PRN) and variable dose protocols were now in place and kept in a separate file to the MAR. We saw each person prescribed PRN had guidance in place indicating the dose and frequency, minimum time between doses, maximum dose that could be given, if the person could communicate to staff they required PRN and the possible side effects.

However, we noted inconsistencies with the recording of PRN medicine usage and explanation of codes used. For example the code letter 'E' indicated that medicines had been either refused or destroyed, however whenever 'E' was used on the MAR chart, it had not been documented which of these two instances had occurred. We saw a person was prescribed Lorazepam PRN and the staff had signed that this medicine had been given daily but there were no notes on the reverse of the MAR to indicate why the medicine had been required.

We saw a range of medicines audits were completed on a daily, weekly and monthly basis. A MAR record review was completed each day after the medicines round to ensure MAR charts had been completed fully

and correctly, all medicines had been given and counts of remaining stock completed. A five a day stock audit was carried out, with five different people's medicines being counted each day to ensure enough stock was remaining. Any discrepancies or issues had been recorded; however action taken or outcomes had not been documented.

This is a breach of Regulation 17 (2) (a) as the information was not up to date, accurate and the information had not been used to demonstrate action and improvements had been made.

Whilst reviewing medical records we saw one person had been consistently refusing to take their medicines. The home had liaised with the GP and an agreement had been made to administer medicines covertly. Medicines has since been taken consistently at the prescribed times.
We did note that whilst people given medicines covertly had GP authorisation in place, liaison with the pharmacist had not always taken place, to ensure this was done correctly.

During the inspection we looked to see how the provider ensured there were sufficient numbers of staff on duty to meet people's needs. We found staff deployment was formally calculated based on people's dependency. The manager told us people's care needs were assessed each month and the home's staffing levels were reviewed in line with people's dependency.

The staffing numbers during the inspection were; three care assistants and one nursing assistant on Evans unit during the day, which decreased to a nurse and a care assistant at night. Four care assistants and a registered nurse on Gerard during the day, which reduced to one nurse and two care assistants at night; and one senior care assistant and a care assistant on Pilling both day and night. In addition to this, there was a domestic member of staff on each floor, the kitchen staff, a home manager and administrator.

At this inspection and our previous inspection, we received no concerns regarding staffing levels on Pilling. However at both inspections, Evans and Gerard, where people are more dependent on staff, concerns have been raised as having insufficient numbers of staff deployed. A person said; "No there isn't enough staff, I think it's because there isn't enough money in care." A relative told us; "For the level of people who wander about on this floor, the staffing ratio is not great."

We asked staff whether they felt they could meet people's needs based on the staffing numbers currently deployed. A staff member told us; "At night it is a ratio of about one staff member to 10 people; we clean too but we can manage." A second staff member said; "We can meet needs but this is at the expense of not being able to spend as long with each person as you would like, we don't have much time for chatting to people. At night we have two staff and a nurse on this floor, more bodies would be useful." A third member of staff said; "We have four staff at the minute and have a mixed bunch of people, it's hard to keep your eye on them all. Accidents do sometimes happen as we can't be everywhere. We used to have five staff on here until recently." A fourth member of staff said; "We do sometimes need to request staff to come to help us from other floors. I worry this could leave that floor short when it happens."

We recommend the provider re-evaluates the current dependency tool, to ensure there are sufficient and consistent numbers of staff available, to safely meet the care needs of people living at the home.

We looked at eight staff personnel files to check if safe recruitment procedures were in place. We found robust checks were completed before new staff commenced employment at the home. The files contained a cover sheet which ensured all required documents and checks had been carried out. Each person's file also contained an application form, full work history, interview notes, proof of identity, two references and a Disclosure and Barring Service (DBS) check. A DBS is undertaken to determine that staff are of suitable

character to work with vulnerable people. We noted a risk assessment had been completed for a person who disclosed receiving a reprimand when they were younger, to mitigate any risks to people using the service.

As part of the recruitment process, potential nursing staff had also been asked to complete written exercises, these included explaining the actions they would take to deal with a specific safeguarding concern and being asked to write a person centred care plan for a specific issue, such as managing a grade four pressure area or dealing with someone who is non-compliant with their medicines.

We looked at the systems in place with regards to cleanliness and infection control. Overall, we found the home to be dated and in need of re-decoration but it was clean. There were some strong smells of urine early in the day but these had diminished during the inspection. A relative told us; "[Manager's name] has had everywhere deep cleaned since they arrived. However the chairs in the lounge need replacing, as they still have a smell of urine when you sit on them, it must have seeped into the foam. The toilet is near to [relatives] room has no ventilation. Smells go up and down the corridor making it unpleasant."

We checked bathrooms and toilets and found they were clean and equipped with appropriate hand hygiene guidance, paper towels, liquid soap and foot operated pedal bins. Cleaning schedules were in place and checked at regular intervals by the manager to ensure work was being completed and we observed staff wearing PPE (Personal Protective Equipment) either when assisting people with care tasks or during meal preparation. This would help reduce the risk of the spread of infections.

We saw regular maintenance checks were undertaken to ensure the building was safe. This included regular checks of portable appliances (PAT), the nurse call system, asbestos, lifts, hoists, gas safety, equipment in the sluice room, weighing scales and the electrics. The home held certificates verifying when the work was undertaken and when the next inspection would be due.

We saw each person living at the home had their own PEEP (Personal Emergency Evacuation Plan) in place which provided staff and emergency services with all the appropriate details about how to evacuate people from the building safely in the event of an emergency. These were stored next to the front door, along with a grab bag which contained relevant aids and supplies for people to use in the interim of putting appropriate arrangements in place if required.

Requires Improvement

Is the service effective?

Our findings

We looked at eight care files and saw each person had a Malnutrition Universal Screening Tool (MUST) in place; this is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. We saw these had been completed and updated timely to reflect people's changing needs. However, referrals had not been made to dieticians in line with the MUST assessment score, where weight loss indicated this was required. For example two people had consistently lost weight over a three month period and had been rated as high risk on the MUST. A referral should have been made to the dietician as per guidance but this had not been done for either person. We also found their care plans had not been updated to implement measures to mitigate the risk of further weight loss. For example, that both people required fortified diet and increased snacks between meals and milky drinks.

We found there were no food and fluid records in place and staff did not document in daily records what people had eaten or drunk. This meant the provider could not demonstrate that people had been provided with fortified drinks and snacks, consumed enough fluids throughout the day or what people who were losing weight had consumed. This type of information would be required by a dietician.

This was a breach of regulation 14 (4) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not sought specialist nutritional advice and nutritional records had not been maintained to prevent unnecessary weight loss.

The service had weekly and monthly weight monitoring charts in place, however we saw these had not been completed consistently. Monthly weights were being documented reliably on the MUST, but for people who required more frequent weighing due to losing or gaining weight, we were unable to confirm from the documentation this had been done.

We found documentation in care files and the kitchen relating to people dietary needs were out of date and incorrect. Kitchen notification sheets were in place which indicated a person's requirements. Copies of these were kept in the care file and the kitchen. When looking at the information board in the nurses office on one floor, we saw it stated one person required a pureed diet and custard thick fluids, however the notification sheet in both their care file and the kitchen, along with guidance from the Speech and Language Specialist (SaLT), stated this person required a mashed diet with syrup thick fluids. We asked a staff member serving meals, who confirmed the person was on a pureed diet and custard thick fluids. The chef showed us the daily meal request sheet; sent to them each morning to indicate people's meal choices, which also stated the person, required a pureed diet. We were later told by a nurse, that the person had been in hospital recently and it had been recommended to change their diet following this admission. This was why the information board and daily meal sheets had been amended, but the care plan and notification sheets still required updating. We also saw four pureed meals were sent daily to one floor, despite no care plans or notification sheets indicating people required these.

When reviewing one person's care file, we saw they were not to have meat, due to medical issues which led to a difficulty in digesting this. However the chef told us the regional support manager had instructed the

kitchen to provide this person with meat as this was the family's wishes and they should not be deprived of having meat should they choose to have it. We saw nothing in the care file to indicate the person's family had made this request or that it was safe for them to eat meat.
We saw no food and fluid records were in place. A staff member confirmed the regional support manager had removed the charts stating staff didn't need to complete them. We were told during feedback at the end of the inspection that food and fluid charts would be re-introduced immediately.

This is a breach of Regulation 17 (2) (c) as discussions and decisions taken in relation to care and treatment had not been accurately recorded.
Despite some issues with referrals to dieticians, we saw overall the service worked closely with other professionals and agencies to meet people's health needs. Involvement with these services was recorded in people's files and included general practitioners (GP), Later Life and Memory Services (LLAMS), Approved Mental Health Professionals (AMHP) and speech and language therapists (SaLT).

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff confirmed they had received training and had an understanding of both. One staff member told us; "DoLS stands for Deprivation of Liberty, it's if people can't make decisions for themselves, we try and meet their needs as best we can." Another said; "DoLS is used when taking away people's liberty, such as having to keep someone here for their safety and in their best interest." Staff told us information relating to DoLS was kept in care files and on the information boards in the nurse's office.

From looking at the homes DoLS file, people's care files and information boards, we saw the provider was not working within the principles of the MCA. DoLS for people deemed to deprived of their liberty had yet to be submitted, whereas applications that had previously been submitted and granted, had expired with no re-application submitted. The information board on one floor indicated that 12 people were under the DoLS framework; however we found no DoLS currently in place or in date for anyone on that floor. We were told the new interim manager had reviewed this area and was in the process of assessing and completing applications, although the focus had been on new applications, rather than re-applying for people whose DoLS had expired.

This is a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; safeguarding service users from abuse and improper treatment. This was because a service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

We asked people living at the home for their opinions on the quality of the food. One person said; "The food is lovely. I have had a nice dinner. It's always very hot and you get loads." A second person said; "I get a good meal every day." A third person; "There is always a drink going round. I never need to ask for more but I know if I did it wouldn't be a problem." A fourth stated; "Choices with food are good. I am easily pleased that way but the food is always good." A relative said; "Food always looks grand and plenty of it." A second relative; "[My relative] tells me the food is good. They are not losing weight so it must be."

We observed the meal time experience on all three floors of the home during the inspection. A weekly 'dignity in dining' audit was completed to ensure the aim of the service regarding meal times had been adhered to. The aim was 'to create a homely dining atmosphere so people can enjoy every meal'. The home aimed to achieve this through ensuring dining tables had been set properly, menus were available, people had been greeted upon arrival and seated at a place of their choosing and they had been offered a drink and a choice of meal.

Our observations showed the provider achieved this. People approaching the dining area were greeted warmly and asked where they would like to sit. People were given a choice of where they would like to eat, including the lounge or their bedroom. Tables had been set with table cloth, napkins and cutlery, with a menu on display. For lunch people were offered a choice of roast pork dinner or corn beef salad, with other options such as sandwich or omelette available should people not like either meal choice.

Staff had been deployed effectively to support meal times. On one of the units five staff shared tasks between them, with two supporting people to eat whilst the remaining three served food and drinks and cleared away dishes once people had finished. We saw staff supporting people to eat did so at the person's own speed, waiting for indication they were ready for another mouthful before providing one. When asked staff were knowledgeable about people's dietary requirements, verbally confirming who received a mashed or pureed diet and whose meals required fortification.

People living at the home and their relatives told us they felt staff were sufficiently trained and had the correct skills to provide effective care. A person told us; "Staff know just how I like things to be done. They are grand." A second person said; "I'd say they get a lot of training." A relative said; "The staff do a wonderful job. They are very clued up and know people's needs." A second relative told us; "Staff seem to know what they are doing. They are pulling the wool over my eyes if they don't and are very good at acting."

We looked at the homes staff training documentation. Training records and completion was recorded electronically. Staff completed a comprehensive induction training package, which included key sessions in moving and handling, infection control, health and safety and safeguarding. On-going training completion was monitored and reminders provided to staff when any training was due to expire. We looked at the training matrix and saw that 90% of staff were up to date with refresher sessions in areas such as safeguarding and equality and diversity, however only 74% were up to date with safer handling training and 60% with manual handling. We were told sessions had been scheduled for all staff to become up to date over the next three months. We saw evidence that the Care Certificate was in place at the home. The Care Certificate was officially launched in March 2015 and employers are expected to implement the Care Certificate for all applicable new starters from April 2015.

We asked staff for their opinions on the training provided by the home. One member of staff said; "They are keen on us keeping up with training, they get on to us if it's not done and in date." Another told us; "All the training done over the last year or so has been on computer, this is done regularly."

We saw evidence in the staff files we viewed, that competency checks and observations of practice had been completed. These had been done in a range of areas including people handling, personal care, meal time support and completion of care records.

Staff told us they received supervision and found this useful. One said: "Yes, we have this every six months or so." Another told us; "Yes, supervision is done every six months." Whilst a third stated; "I had supervision about three weeks ago, before that not for quite a while."

The home had a supervision matrix in place to monitor completion. We noted there had been a noticeable improvement in completion over the last five months, with over 90% of staff having completed supervision since January 2017. Prior to this completion had been sporadic and varied between staff members. Some had at least two meetings documented in 2016, whereas others had not received supervision since 2015.

We looked at how the home sought consent from people. Staff were knowledgeable about the need to seek consent, one told us; "I do this by talking or asking people. Don't assume, always ask." Another said; "I always ask. If people don't want intervention at the time, I will walk away and then go back and ask again. It's important to respect their wishes." Care plans contained consent forms, which had been signed by either the person themselves or their representative. During the course of the inspection we observed staff knocking on people's doors and waiting for a response before entering, staff asked people if they wished to take their medication and would they like something to eat or drink. Each person we spoke with told us staff sought their consent, with one saying; "The staff treat me with respect, they ask me first before doing anything." A second said; "I am always being asked permission for one thing or another. They are good girls."

The home was tired and in need of upgrading and decorating. We saw that paintwork was scuffed throughout the home, which had a negative impact on the general appearance of the home. Although there had been some attempt to make the environment more suitable for people living with dementia such as bedroom doors painted a different colour to the walls, letter box slots and knockers were hanging off the doors and memory boxes outside people's bedrooms were empty.
We found the home did not consistently have adequate signage features that would help to orientate people living with dementia. We saw limited evidence of dementia friendly resources or adaptations in any of the communal lounges, dining room or bedrooms. This resulted in lost opportunities to stimulate people as well as aiding individuals to orientate themselves within the building.

The interim manager told us that the home needed upgrading and work was underway to address this. The provider had replaced the roof on pilling but this had been with large skylights over the lounge area which made the room hot and the television was not visible due to the searing sunlight. We fed this back during the inspection as we found it uncomfortable and we were told blinds had been ordered.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

The people living at the home told us they were happy with the care they received and described the staff as caring. One person told us; "Staff are good, they treat us well." A second person said; "Most of them are very good. I would recommend this home to others. It is very good." A third person said; "It's a lovely place, staff are so caring." A fourth person; "I can't say much more other than they are lovely people and I enjoy living here." A relative told us; "Very caring, haven't seen anything else and don't expect to."

We saw staff interaction was friendly and caring and observed appropriate displays of affection between staff and people throughout our visit. People were calm and relaxed in the presence of staff and we saw staff were attentive to people's needs. It was a warm day when we were at the home and we saw staff offered people drinks every thirty minutes and were encouraging people to; "Keep up their fluids." People complained of being warm so staff put fans on and asked people to let them know if they were too cold or sat in a draft. A staff member noted oedema in a person's legs. They encouraged the person to elevate them and kept returning to check that the person's legs were elevated and they were okay. Throughout the inspection a person was shouting out, staff sat with them stroking their hand, we saw them respond to the staff with a smile and settle.

People told us staff treated them with dignity and respect and we observed people were treated with kindness during the inspection. We observed staff knocking on bedroom doors and discreetly asking people if they would like to be taken to the toilet. A person told us; "Staff always knock on my door. They wait until I tell them to come in before they do." A second person said; "The staff treat me with respect and nothing other."

The staff we spoke with were also clear about how to treat people in this way when delivering care. One staff member said; "Take people to bedrooms to change." A second staff member said; "Take to a private place if needed, ask people what they want, make sure doors are closed." A third said; "Ensure doors are shut, we use a private area and cover them with a towel."

People told us staff promoted their independence where possible and we saw this in action during the inspection with tasks such as eating, drinking and mobilising with the use of a zimmer frame. The staff we spoke with displayed an awareness and understanding of how to promote people's independence. One said; "We build relationships with people so we know what they like to do for themselves and encourage them to maintain as much independence for themselves as possible."

We saw staff communicating clearly with people during the inspection such as crouching down at the same level and speaking closely to their ear so they could hear what was being said. People had communication care plans in place. This took into account if people needed glasses or hearing aids and how they communicated with people. The care plan took in to account people's preferences and detailed whether people liked to be supported by male or female staff.

We saw staff offering choice and this was incorporated into the care plans we looked at. For example; the

care plans indicated people could choose their own clothes, what they ate, how they spent their day and people's preferences were listed. Staff told us they would also confirm with people their choices as they provided care and wouldn't just assume the details in the care plans were how people would always want their care to be delivered. A staff member told us; "Ask them what they would like." A second staff member said; "At meals time it's about showing the residents what is available, giving people a choice. Sometimes we will suggest things but if they are not happy with this we will swap it. I ask people where would they like to sit and what they want to wear."

We saw care files were stored securely which ensured people's confidential information was protected.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they thought staff were responsive to their need. One person said; "I do my own thing. I get up when I want, I go to bed when I want and I get a shower when I want." A second person said; "I let them know that I'm going to bed out of courtesy but they don't stop me."

We looked at what arrangements the service had in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at eight care files and saw prior to any new admission a pre-assessment was carried out with the person and their relative(s). People's support needs and wishes were documented on their care plans so that staff knew exactly how each person wanted to be cared for. These plans captured essential information required for the person to maintain their independence and provided a detailed breakdown on how this was to be achieved. Information such as allergies, prescribed medicines, and current equipment used to reduce any risk, understanding and communication requirements and preferences in care were all considered.

The detail from the pre-admission documentation was then transferred onto individual care plans within people's care files. The care files we looked at detailed appropriate plans to ensure the person was being supported safely and in line with their wishes and preferences. We noted care plans were only used when there was an assessed need. This evidenced that the service considered each person's individual need. If a new need was assessed then a care plan with detail in that area would be added. This indicated that people's care files were individual and person centred. We noted t these were reviewed in line with the services procedural guidance and people were involved where appropriate.

Care staff told us they were allowed time to read people's care files and updated information. We spoke with a new member of staff who told us this was also part of the induction process. A further member of staff added; "It is important we keep up to date with people's needs. We also have staff handover before each shift to obtain any updates when people's circumstances change."

Daily reports provided evidence to show people had received care and support in line with their care plan. We noted that records were detailed and people's needs were described in respectful and sensitive terms.

The home had a tissue viability file in place. This included a matrix which listed anyone within the home at risk of contracting a pressure area along with the type of bed and mattress in place, their Waterlow score, current risk level, current skin condition, if position record and body map was up to date and if they had a skin integrity care plan in place. We saw that body maps also clearly documented any skin issues along with the treatment plan in place.

The service had a complaints procedure in place. The procedure provided directions on making a complaint and how it would be managed. This included timescales for responses. We found the service had systems in place for recording, investigating and taking action in response to formal complaints. People told us they felt confident in making a complaint. Comments from relatives included;, "We had one concern, this was when [our relative] had a fall. I must say this was sorted and extra measures were put in place. We were very

happy with the outcome." Another relative commented;, "I would speak with the manager or care staff if I had any problems. I feel confident any concerns would be dealt with." People who used the service also spoke with us about the confidence they had with the complaint procedure. One person said; "I do have my moments and my concerns are always listened to." Another person said; "I know who to complain to, up to now I have never had reason to complain, but if I did, I am pretty sure things would be sorted."

The service had received various compliments from family members thanking them for the care provided to family members. One comment said, "Thank you for looking after [our relative] everybody made them feel at ease and kept them comfortable with meant a lot to us. It is not easy putting a loved one into a care home but after seeing the care [our relative] received, proves we made the right decision when we chose Ashton View."

The service used an additional range of systems to gather people's feedback in order to monitor the effectiveness and quality of the service provided to people. This included feedback via quality assurance questionnaires, residents and relatives meetings and ensuring time was allocated to speak with people when requested. We saw 15 completed quality questionnaire's had been received at time of inspection; however these were from the previous year. An action plan had been formulated from the results of the previous year's survey and discussed with people and their relatives. The manager informed us the current year's survey had been sent and the service was awaiting them to be returned. We noted the last resident meeting was held in February 2017 and areas such as the decoration of the service and privacy and security had been discussed.

As part of the inspection we looked at the activity programme provided by the home. We noted two activities per day were planned and this was to cover each of the three floors. This meant if the activity was happening on the second floor then people from the other floors did not participate. We spoke with the manager about this who informed us the service was currently managing with one activities coordinator and was in the process of planning for a second person to start. The manager acknowledged that this had been identified as an issue. We observed very little stimulation of people on each of the units throughout the day of inspection. Comments we received from people supported our observations. One person said. "There are no activities really, not much going on." Another person said, "They sometimes have a singer on but that's about it really." One relative stated, "They are short on activities. They always seem to have the television on all day and not much radio. Up to now I have seen someone come in to do arm chair exercises and I have seen bingo once in the past 12 months. Every now and again there may be a singer but that's about it."

We recommend that the provider review the activities programme in line with people's preferences.

Inadequate

Is the service well-led?

Our findings

At our inspection on 22 October 2015, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in regards to safe care and treatment and governance.

The home was rated as requires improvement overall and in the key lines of enquiry (KLOEs) for; safe, effective and well-led.

At this inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regards to regulation 12; safe care and treatment (two parts), regulation13; safeguarding service users from abuse and improper treatment (two parts), regulation 14; meeting nutritional and hydration needs and regulation 17; governance (two parts). We also made three recommendations in relation to reviewing the dependency tool used to calculate staffing, the environment and activities.

This meant the provider had failed to improve the overall rating of the home from 'requires Improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case as we found the quality of care received had deteriorated, which meant the quality of service provided to people living at the home was not continuously improving over time.

We found the operations files for the running of the home were chronologically ordered so information was readily accessible. We saw the files had been condensed since our last inspection but the required information remained. We looked at the recruitment tracker, medication audit, falls and infection control audit, health and safety audit, care plan and home audit.

We saw the scope for audits was comprehensive and the operations managers visited the home regularly and carried out an additional monthly audit. However, we found the food and fluid charts had been removed by the management which meant a clinical assessment could not me made as to whether the people were receiving the required calorie intake in order to inform their treatment. The audits had also not identified that one person had run out of medicines for the past two consecutive months, safeguarding referrals had not been made and care plans had not been updated timely to mitigate risks. We saw the audits had been ineffective in identifying the regulatory breaches identified during the inspection. The audits were scored but there were no details as to what this meant or the actions that had been implemented to drive improvements.

This meant there had been a breach of Regulation 17 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not effectively assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity.

At the time of our inspection, there was no registered manager in post. The registered manager for the home had left in April 2017 and we had received a notification from the provider informing us of this. 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.

The provider was in the process of recruiting to the registered manager's post and a regional support manager within HC-one was overseeing the daily running of the home. People, their relatives and staff spoke favourably of the regional support manager and indicated they felt there had been improvements since their appointment. A relative said; "The home had declined but things have improved since the new manager started and they seem to be on the ball and sorting things out."

The regional support manager was on leave when we undertook the inspection and management oversight was being provided by another manager from within HC-One. They had only been in the home two days prior to our visit and acknowledged they were unable to answer some of our historical enquiries as they had not been present at the home during that period. We gave feedback following the inspection and found the management to be open and transparent. Both the interim manager and the area manager were honest regarding outstanding areas to be addressed. They told us they were committed to addressing the issues identified during the inspection. Following the inspection, we received an action plan from the interim manager identifying a plan of actions to address the areas identified timely.

We asked staff what it was like to work at Ashton View and whether the provider nurtured a good culture within the home. A staff member told us; "Fine, no problems." A second staff member told us; "The atmosphere is pretty good here." A third said; "Manager is lovely, very approachable." A fourth said; "Things are getting better. It's just now a challenge to get used to all the new paperwork." A third; "Can't say there are any issues with overall staff mood." A fifth; "We don't have a unit manager now but everyone knows what they are doing."

We received mixed views from staff as to whether they perceived the home to be well-led. We attributed this to the recent changes in management and the instability this can bring when further changes are implemented. A staff member told us; "The new stand in manager is really good. They are making things much better here, bringing in lots of new stuff." A second member of staff said; "I feel well supported, if I ever have a problem I can go to the management." A third staff member said; "Because of change of manager at the moment, I would say no. The new one is very good, but each one that comes in has their own way of doing things which makes it hard work to keep up." A fourth staff member said; "All the changes are traumatic. It's hard to keep morale up. The previous manager didn't do much but the new one is on top of paperwork. The removal of the food and fluid charts was worrying though and I felt vulnerable before when you came in asking for them."

We saw team meetings were conducted regularly. There was a daily flash meeting when the home manager met with a senior or nurse from each unit and discussed staff concerns, people and the day ahead. There were monthly team meetings and minutes were taken at all team meetings and were displayed with an action plan. We looked at the minutes from the most recent staff meeting. We saw topics such as recent achievements, training, paperwork changes, personal care charts and infection control were all discussed. Monthly status meetings were held on each floor attended by the nursing staff and home manager. During these meetings each person using the service had been reviewed with any issues or concerns highlighted and an action plan generated to address.

Staff said meetings were regular and they felt able to contribute. A staff member said; "Yes, we do [have meetings]. Recently these have been monthly, they were less frequent before, probably once a year or so." A second staff member said; "Once a month. Can bring things up at the meeting." A third staff member said; "Yes, we have meetings. They used to be at a really awkward time for night staff, as held in the afternoon. Be like asking day staff to come in at two in the morning. But this has been changed to 6.30pm which is better, I don't always attend but we get a copy of the minutes so we know what was discussed."

We noted HC- One had a staff recognition award and other incentives in place to promote staff morale and acknowledge staff contribution to the home. We saw there was a ballot box in reception where people living at the home, relatives, staff and healthcare professionals could nominate a staff member working at Ashton View to receive employee of the month. This was drawn bi-monthly and the winning staff member received a £50 shopping voucher. There were also incentives to nominate a team and they could win £100. HC-One had a staff awards scheme so staff could benefit from discounted use of hotels, restaurants and food. If staff recommended a friend to work with HC-One and the employee was successful and remained with HC-one for three months, the staff member received a £250 salary bonus. Incentives had also been introduced to recruit nurses which included a newly recruited nurse being given an iPad for taking up employment with HC-One.

We saw there were accreditation incentives to support staff to progress. We spoke to staff that had undertaken training with HC-One to become nursing assistants which had involved them attending training in order to undertake certain nursing tasks. There was always a nurse on duty in the home for them to refer to, and who maintained responsibility for clinical tasks, but it meant staff had been supported to develop and increase their responsibility.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate the risks. The provider had not ensured people's medicines were available in the necessary quantities at all times to prevent the risks associated with medicines that are not administered as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found the provider had not protected people against the risk of harm associated with safeguarding people from abuse and improper treatment. People living at the home were being deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not sought specialist nutritional advice and nutritional records had not been maintained to prevent unnecessary weight loss.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This was because; - the information was not up to date, accurate and the information had not been used to demonstrate action and improvements had been made. - discussions and decisions taken in relation to care and treatment had not been accurately recorded.

The enforcement action we took:

Warning notice