Barchester Healthcare Homes Limited

Ashchurch View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashchurch View is a large purpose built care home set over two floors. The home has three units which support people with different needs. Each unit has a lounge and dining room with an adjacent kitchen. People's bedrooms have a private toilet and shower facility. People have access to a secure garden, coffee area and activities room as well as a hair salon.

This inspection took place on 6 and 8 September and was unannounced. Ashchurch View provides accommodation for 60 people who require nursing and personal care. 54 people were living in the home at the time of our inspection. This service was last inspected in November 2015 and was rated Good overall. At this inspection we found the service was rated Requires Improvement overall. We will be asking the provider for a report on the actions they plan to take to achieve a rating higher than 'Requires Improvement'

There was no registered manager in place as required by their conditions of registration. 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. There has been a new manager in place since May 2017. The manager had submitted an application to CQC to become the home's registered manager to ensure the provider would meet their registration requirements.

Information of concern around the inconsistency of staffing levels in Ashcurch View had been raised prior to our inspection. CQC had initially acted by requesting confirmation and assurances from the provider that people were being cared for by a sufficient number of staff. This inspection was prompted in part by these concerns and to follow up on the actions the provider stated they were taking.

There had been recent changes in the staffing and management of the home. People had been supported by agency staff and staff had remained flexible to ensure they remained safe in the home. The manager was actively recruiting a permanent staff team to ensure people there were sufficient and familiar staff deployed to meet their needs.

People's support needs and risks had been assessed and were managed well. Their care records had been reviewed however improvements were needed to ensure the care people required and had received would always be recorded. People received their medicines in a safe and timely manner and were referred to health care services when their needs had changed.

Quality assurances systems were in place to monitor the quality of the service being provided and actions were being taken by the manager when they had identified areas that required improvements. Further improvement was needed to ensure management actions would always be recorded to enable effective monitoring and evaluation of action taken to improve the home.

People told us they enjoyed living at the home and they felt safe. We observed that staff were courteous and polite towards people. Staff understood the importance of respecting people's dignity and privacy. Staff supported and encouraged people to make their own decisions and choices.

Staff had been trained to carry out their role and were knowledgeable about good care practices and their responsibilities to protect people from harm and abuse. Staff felt supported by their seniors and new managers. Plans were in place to ensure staff received one to one support meetings to discuss their role and self-development. Adequate recruitment processes were in place to ensure people were cared for by suitable staff, some improvement was needed to ensure people's needs were continually being met in a timely manner.

The manager was taking action to further develop the activities for people. Additional staff had been recruited to develop a range of activities to be available in the home and community. Concerns from people and their relatives were addressed immediately. People told us they enjoyed the meals and snacks provided. People with special diets or preferences were catered for. A new chef who had recently been appointed planned to consult with people about the food being provided.

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

This service was not always safe.

People had not always been supported by a consistent staff team. The manager was actively recruiting new staff to ensure people were being cared for by permanent and familiar staff.

People's risks had been identified and were being managed well, but not always recorded consistently.

Staff were knowledgeable about their role and responsibilities to protect people from harm and abuse.

Adequate recruitment processes were in place to ensure people were cared for by suitable staff.

People received their medicines a prescribed and the provider was implementing a new medicines system.

Is the service effective?

Good

The service was effective.

Plans were in place to ensure all staff received the support and training they required to care for people and enhance their personal development.

The manager and staff understood their responsibilities of provide people with choice and the principles of the Mental Capacity Act.

A new chef had been employed to review and improve the quality of meals being provided.

People were supported to maintain their health and access other health care services.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with respect and

dignity. People and their relatives commented on the good nature and kindness of staff.

Staff spoke positively about people and were able to tell us about their likes and dislikes.

Is the service responsive?

Good

The service was responsive.

People received care which reflected their needs and wishes. People had detailed care plans in place which provided staff with the information they needed.

People's social needs were not always met; however an additional activity coordinator had been recruited to provide social and recreational activities throughout the week.

People and their relatives felt confident that any concerns they might raise would be acted on.

Is the service well-led?

Requires Improvement

The service had not always been well led.

The new manager had submitted their application to become registered with the CQC.

There had been a number of management and staffing changes in the home and we found the new manager was making improvements in the home. However time was needed for them to complete and evaluate the effectiveness of their improvement actions.

Systems were in place to monitor the quality of the service provided. Improvements were needed to ensure management actions would always be recorded to enable effective monitoring.

The manager, deputy manager and staff were committed to improving the lives of people who lived there.

People, relatives and staff were confident in the new managers.

Ashchurch View

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 inspection took place on 6 and 8 September 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist professional advisor and an expert by experience. The expert by experience's area of expertise was in caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the inspection history of the home and information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke directly with 18 people and other people in groups as well as four relatives. We also spoke with several members of staff including six care staff, two nurses, the activity coordinators the maintenance manager and the head chef as well as the manager, deputy manager and regional director. We looked at the care records of nine people and staff files including recruitment procedures, as well as the training and development of all staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

Information of concern around the inconsistency of staffing levels in Ashcurch View and concerns regarding staff turnover had been raised by staff and relatives with CQC prior to our inspection. We found that a number of agency staff had been used in the home due to staff sickness and staff holidays. Additionally some staff had terminated their employment at the home. Staff shared with us there had been times when sufficient numbers of suitably qualified staff had not been on duty to support people. From conversations with staff and reviewing staff rotas, we determined that on occasions there had not always been a trained member of staff on duty on the residential unit to administer people's medicines. The unit had relied on the flexibility of staff who were trained in medicines to come in to the home to specifically administer people's medicines or had requested the deputy manager or staff from the other units to carry out the medicines round.

The home had a 'whole home' approach when deploying staff across the home. The manager explained that staff were assigned to units or departments but were required to support other people on the units when needed. We found that the deployment of staff from other units presented potential hazards to people as staff did not always know people's individual needs or risks, however, arrangements were in place to reduce the risk of people's needs not being managed. For example, we observed staff directing the visiting staff as required ensuring people received the care they required and a comprehensive and informative handover took place between each shift. Staff were provided with daily handover sheets which contained information about peoples current condition and risks associated with their needs such as, nutritional intake, tissue viability and choking risk which provided them with clear guidance on how to support people and reduce risks to their well-being.

We received mixed comments from staff about the staffing levels and deployment of staff around the home. Most staff felt the units worked well when a full staff team was in place especially if they were supported by a hostess who provided additional support during the mealtime periods. A senior staff member shared with us that people's needs were not always met in a timely way when they were focused on administrating people's medicines during the mealtime period and if the care team were not supported by a hostess. They told us having a hostess on duty allowed them the time to support people with their personal care and medicines. One staff member also confirmed this view and said, "The staffing can work well when there is a hostess on." The manager had held staff meetings in the units to hear the views of staff around staffing levels. We were informed that as a result of their findings another hostess had been recruited. This meant that, staff and people would be supported by an additional hostess during the breakfast and lunchtime period seven days a week on two of the three units.

People and their relatives commented on the staffing levels in the home and most felt that they were now being supported by regular and familiar staff members. Comments included: "The main problem is the lack of staff", "The carers are doing a marvellous job but have a lot put on them" and "They could do with some more really." One relative said, "I don't feel there has been enough staff at times, especially if staff have phoned in sick at the last moment. There has been a lot of agency staff but it's getting better." However the manager had reassured and informed people and their relatives about their plans to support and manage

the staffing levels as well as the recruitment of new staff.

We discussed the staffing levels with the manager who had reviewed the deployment of staff and had examined the response times of staff when people had requested assistance using their call bell. They had analysed that there had been a trend in the delay of staff responding to people's requests for assistance over the breakfast and lunchtime period. We were informed that as a result of their findings another hostess had been recruited. This meant that, staff and people would be supported by an additional hostess during the breakfast and lunchtime period seven days a week on two of the three units. We were told that on the third and smaller unit, the manager, deputy manager or another staff member would be made available during the meal times. The lunch time was a protected period of time and that all staff were deployed to focus on people's dining experience and nutritional and fluid intake. The manager was taking action to review the staffing levels and ensure people were kept safe within the home. The provider was in the process of actively recruiting to reduce the number of staff vacancies in the home as well as improving the support systems for the established staff team. The manager told us the actions they were taking to recruit and retain staff which included implementing the provider's benefit and incentive schemes. The manager said, "It's been tough for staff. Recruiting good staff has been my biggest challenge and holding on to the ones we've got. I need to make sure they (staff) are feeling safe in their role and I know we have some work to do about providing the staff with the support they need and deserve. They have worked hard to ensure the residents have remained safe." Whilst supporting people with familiar and regular staff had been difficult; staff told us the managers had listened to their concerns when people required extra personalised support. One senior staff member said that additional staff had been made available on their unit when people required extra support and reassurances especially in the evenings.

Safe recruitment practices were followed before new staff were employed to work with people. Previous employment and criminal checks were carried out to ensure staff were of good character and suitable for their role. Discrepancies in the employment histories of new staff were discussed at interview but not always recorded as part of the interview process. This was raised with the manager who told us this would be added to the interview checklist to ensure it was recorded.

People's risks had been identified and assessed by staff. Staff were knowledgeable about people's risks and could tell us about the people they regularly supported. Most records showed that risks associated with people's health and well-being had been documented well and provided staff with sufficient detail to support people and understand their needs. For example, one person had been assessed as being at high risk of developing pressure sores. Their care plan stated that they required a pressure relief air mattress on their bed, a pressure relief cushion on their chair and to have their position changed every three to four hours. We found that appropriate equipment had been provided at the correct setting and records of their three to four hourly positional changes had been completed which indicated that their risks were being managed and monitored in line with their care plans.

Risk assessments and guidance was in place for people who required support with their mobility and transfers and records showed that occupational therapists had provided additional advice and support when required. We observed safe moving and handling practices and some files contained additional instruction booklets and safety information relating to the use of the equipment. One person who needed to be transferred using a hoist told us they were always safely transferred using the hoist by two staff members. People's care records also contained personal evacuation plans in order to direct staff on the support they would require in the event of a fire.

Some improvements were needed in people's care records to ensure that staff had the information they required to manage and monitor people's risks. The manager and deputy manager acted promptly when we

found some discrepancies in the management of some people's risks. For example, there were inconsistencies in the information for one person who required prescribed thickener to be added to their drinks to prevent them choking. The deputy manager responded to our concerns and ensured that staff were clear on the correct amount of thickener to be added as recommended by the speech and language therapist. Another person's risk assessment indicated they were unable to use their call bell and required staff to check them every hour whilst they were in bed. Staff told us that they checked the person frequently; however records were not being kept of these checks, although there were records of positional changes every three to four hours. The deputy manager told us checking people's monitoring and drink and fluid intake would be embedded into their daily walk around.

People's accident and incidents had been reported and recorded by staff and entered in to the provider central electronic data base. The incidents were regularly reviewed by the manager and clinical governance team to identify any patterns or trends in accidents occurring in the home. Actions had been taken as a result of the manager's analysis of people's accidents and incidents. For example, one person's medicines had been reviewed and changed as it had been noted that they were experiencing an increased number of falls. The number of falls the person now experienced had decreased as a result of this action.

People's medicines were administered safely by staff who were trained to manage their medicines. We found medicines were stored securely and in line with manufacture guidelines and people were given their medicines as prescribed. People's Medicines Administration Records (MAR) had been completed appropriately when they had been given their medicines with no gaps in the records. Protocols were in place to provide staff with guidance on the administration of occasional medicines such as medicines used to assist people with intermittent pain relief. Safe systems were in place to check that people who self-medicated were doing so in line with their prescription. Records showed that some people had been supported to apply medicinal creams to their skin as prescribed.

Regular medicines audits were carried out to check that people received the medicines they required. Staff had been open and transparent where medicines errors had occurred. Records showed that any discrepancies or errors in people's medicines were investigated and acted on.

The home had reviewed the management of people's medicines. A new medicine administration system was being introduced and staff were in the process of being re-trained by the new pharmacist provider. The new system would further enhance the safe management of people's medicines as staff would administer people's medicines from the original containers. To ensure staff would be skilled to use the new medicine system the manager was also introducing a new medicine competency assessment to be completed following the new pharmacist training.

People told us they felt safe living at Ashchurch View. When asked one person said, "Yes completely safe here" and another person said, "I am very happy. I feel well cared for and feel safe living here. The staff are excellent."

Systems and processes were in place to protect people from the risk of abuse or harm. Staff had been trained in safeguarding people and were knowledgeable about the types of abuse and the actions they would take if they had concerns about people's welfare and suspected they were being abused or harmed. Staff told us they would have no hesitation in reporting any incidents or poor practices to a senior member of staff or the managers. All staff were aware of the internal processes of reporting safeguarding concerns. Information about the provider's whistleblowing procedure was displayed on the staff notice boards and reinforced during staff meetings. One staff member said, "I would have no issue in reporting someone if I saw them doing something wrong". However some staff were not clear about the agencies they should

contact outside the home if they felt the provider did not act on their concerns. The manager reassured us that they would reinforce the home's safeguarding policy and contact details of external safeguarding agencies at the next staff meeting.

Good

Is the service effective?

Our findings

People were receiving effective care from staff who were being trained and supported to carry out their role. Staff told us the management and monitoring of their training had improved since the new manager had been in post. One staff member said, "We are all trained to our job but some of us needed some refresher training. The new manager seems to be on top of that now." The provider's statistical analysis of the home's training matrix indicated that over three quarters of staff had received all the mandatory training to carry out their role. The manager shared with us their training plan to up skill the remaining staff in areas such as supporting people with dementia. Plans were in place for staff to attend a course of dementia awareness training initiated by the provider. Records showed that the majority of staff had competed end of life training and it was planned for further training to be delivered in the next few months. Staff told us they had access to online training courses as well as courses delivered locally by the regional trainers and other health care agencies.

Nurses were supported to revalidate their professional nursing registration. We were told they were responsible for monitoring their own training and requesting additional and refresher training courses as required. The manager was reviewing the skills and training of nurses to ensure they had the skills required to meet people's needs such as sourcing additional in end of life training and other specialist clinical skills.

Other non-care staff were also being supported to develop in their role. For example, staff involved in providing activities were supported to access national and provider resources to develop their skills in meaningful activities and the maintenance person had been booked on to a health and safety course. The new chef would be attending training in specialised diets for older people and for people who lived with dementia. Some staff were being encouraged to become champions in specialist areas such as dementia and infection control to support the staff team to remain up to date with current best practice.

Staff were also supported to undertake National Vocational Qualifications also known as Qualifications Credit Framework in health and social care. New staff completed an induction programme and shadowed their colleagues as well as completing the care certificate in their probation period. One new staff member said they were mentored by an experienced staff member for six days over a two week period. They said "She (the mentor) was brilliant, she told me everything." The managers were also encouraging staff to develop in their role and become champions in their areas of interest and share their knowledge with the staff team such as dementia and falls management.

Prior to our inspection the manager had identified that not all staff had received regular supervisions and appraisals due the turnover in staff who were responsible for line managing staff. They confirmed the newly recruited senior staff would be required to attend the provider's supervision and management course before providing supervision. Records showed that progress was being made to ensure staff received six supervision sessions a year including an annual appraisal to discuss their professional development and goals. Staff told us senior staff or managers were always available if they required additional support.

Senior staff and nurses felt the support they received had improved since the manager and new deputy

manager had been in post. One staff member said, "Things are improving in the home. I definitely feel more supported. The deputy manager and manager know their stuff and always happy to support us."

We checked whether the service was working within the principles of the Mental Capacity Act and whether any condition on authorisations to deprive a person of their liberty were being met. 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 in their best interests and legally authorised under the MCA The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

Staff had an understanding of the principles of the MCA relevant to their role and were able to demonstrate how they embedded their knowledge of the MCA in their care practices. We saw many examples of staff supporting people to make choices about their day such as asking people where they wanted to sit and what they wanted to eat. We observed staff supporting people in the least restrictive way. For example, staff supported one person who became distressed and wanted to leave the building in a respectful and reassuring manner.

Actions were being taken as part of a best interest decision to lawfully gain consent to monitor some people with sensor mats to reduce their risk of falling whilst maintaining their privacy. Staff had applied the principles of the MCA when significant decisions had been made such as specific decisions around people's medicines. For example, records showed that a best interest decision had been made by health care professionals for one person to be given their medicines covertly if they refused their medicines.

The manager had made appropriate applications to the local authority when they had identified that staff and the environment was restricting people's liberty. Authorised applications of DoLS were in people's care records and were being regularly reviewed to ensure they remained in date. Actions were being taken to ensure that people's DoLS authorisation and any conditions were being embedded in to people's care plan to form part of the care planning auditing process.

The manager was looking into the staffing arrangements and deployment around the lunchtime period to ensure people received their meals in a timely and effective manner. Staff were generally attentive to people's needs and people received their meals in a person centred and suitably organised manner. The manager was in the process of recruiting a hostess to provide additional support during the breakfast and lunch periods. The lunchtime was protected which staff focused on supporting people with their meals and drinks.

People enjoyed their meals and were offered a second portion. We found staff serving and supporting people with their meals in a kind and respectful manner. Most people chose to eat in the dining rooms of the units while others ate in the lounge or had their meals served to them in their bedrooms. The dining tables were set with table linen, flowers and a menu. Those people who struggled to read the printed menus on the dining table due to the font size; were either verbally informed of the meals or shown a choice of plated meals which provided them with sensory clues to help them choose their meal. People were provided with specialised utensils and crockery to assist them to remain in independent in eating their meals. For example, some people were given their soup in a two handled mug rather than a bowl.

Most people told us the quality of the meals had recently improved and they were offered an alternative

option if they didn't like the meals available on the day. One person said, "I can always have an omelette if I don't like what's on offer." Other people said comments about the meals such as "Fairly alright. I get enough to eat and drink", "The foods okay but could do with a better choice" and "The meals are getting better. I am told we will be getting more traditional food which I will enjoy."

A new head chef had been employed to drive improvement in the quality of food being served. The chef told us they planned the meals around a four week rolling programme which was scheduled by the provider; however they could be altered to suit the needs and likes of people who lived at Ashchurch View as required. The new chef told us they were planning to meet with people and their relatives to find out more about their dietary preferences and their dining experiences in the home. They recognised the importance of presenting food which looked appetising and pleasing to the eye such as moulded pureed food or foods that people could manage independently such as a greater range of finger food. A staff member commented "The food has not been good for a while, but we have a new chef so things are looking up."

People had access to health and social care professionals. Records confirmed people had been referred to a GP other professionals such as a dieticians, podiatrists, and opticians. For example, records showed that speech and language therapist has visited and assessed people who had been identified as at risk of choking. Staff had clearly documented their recommendations and understood the support people required. The GP visited the home regularly to review the needs and medicines of people and assess new people. One person told us how they had been supported when they became unwell and said "The staff are alright, they look after me well. They got the doctor when I had a bad chest; they were good."

Good

Is the service caring?

Our findings

People had positive views on the caring nature of care staff. We received comments from people such as "Its lovely here, I'm quite happy", "If you have to be somewhere this is a good place to be" and "I get on well with the staff, they're all nice." Staff interacted with people in a kind and compassionate manner. There was a calm and pleasant atmosphere on all of the units.

Relatives also praised the staff and the care their loved ones received. Comments included: "Everyone happy with the care here. I don't want him to move. They look after him well. Always clean and tidy. We have no problems at all" and "The staff are very caring. I am very happy with the way he is supported and how the staff treat me as well." They went on to explain that their relative had put on weight since living at Ashchurch View and that staff had always contacted them if they had any concerns. Relatives told us they were allowed to freely visit the home and were always welcomed by friendly staff.

Staff spoke to people politely and as equals. For example, we observed a member of staff assisting one person who was agitated in the corridor. The staff member reassured the person and explained why they were living at Ashchurch View. They guided them to the dining room and offered the person choice of drinks and told them their lunch would soon be delivered. The person relaxed and thanked the staff member. Later we observed the person chatting with other people at their table. People were encouraged to retain their levels of independence such as walking daily to the dining room and eating with specialised cutlery. One person said, "I get my daily exercise walking to the dining room for my meals. I can be slow but I get there. The girls always walk with me."

People were supported by staff who were interested in their well-being. We found that staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs with staff, staff confidently spoke about them in a compassionate manner. For example, one staff member was able to tell us about the people they were caring for on the day of our inspection, including how they liked to spend their days and the things which were important to them. One person was comforted by holding two fluffy dog toys as their own dog had died shortly before they came into the home. The manager and deputy manager were also familiar with people's preferences and well-being. They spoke knowledgeably about people's progress since being in the home. People's care plans focused on all aspects of their well-being and provided staff with information about their allergies, sleeping preferences, cultural, spiritual and social values as well as their hopes and concerns for the future. People were supported to make decisions about their day and were involved in their care planning. We observed staff actively prompting people to make choices such as where they would like to sit and what they would like to drink.

Staff told us they worked as team to ensure people received good quality of care. Staff made comments such as "The carers here are very good and know the resident's needs" and "We have had to pull together as a team to make sure the residents get the right care. It has been difficult especially when we have been short staffed or had to reply on agency staff but it's getting better. We are here for the residents." An agency staff member also said "Here is one of my favourite homes. The staff are really good and the care is really good."

People's dignity and privacy was respected. Staff ensured people's personal care was given behind closed doors. We observed staff knocking on people's bedroom doors and waited for a reply before entering. People looked clean and had been supported to wear clothes of their choice and helped to wear jewellery or make up. Staff understood that people's individuality and diversity was important and something that needed to be upheld and valued. People were able to personalise their bedrooms. They had items in their bedrooms which they enjoyed and cherished such as pictures of people who were important to them.

Good

Is the service responsive?

Our findings

People were supported to spend their day as they wished either in their bedroom or in communal areas. Their interests and hobbies had been captured by the activities coordinator who told us they arranged and provided a variety of activities in the activities rooms, on the units or with people individually such as melody with music or a parachute activity. They said, "There is not enough 1:1 time though. It's not easy to find time and even when we do it's not for long." Some people and their relatives shared with us that they felt there had been a reduction in activities available for people to join in. One relative said, "There are quite a few external entertainers that come in regularly but there isn't a great deal of activities in between times." However, notices and information around the home displayed posters of past and future events and activities such as PAT dog (therapeutic dog), music and entertainers and chair exercises. Where people had joined in activities, records showed their level of engagement. The activities coordinator also evaluated the effectiveness and outcome of each activity. The activities coordinator was responsible for arranging a small celebration on the days of people's birthdays.

The manager was reviewing the activities and opportunities for social engagement available to people. They had identified that the activities available did not suit everyone's needs and were not always meaningful for some people. They explained that a new activities coordinator had just been recruited to join the activities team and together they would be expected to provide a range of group and individual activities across the home throughout the week. They also had plans to work with staff to help them understand and identify opportunities throughout the day where they could provide meaningful interactions and activities with people.

People received care that was person-centred and responsive to their health and support needs. Before they had moved into the home people had been assessed to ensure their health and well-being needs could be met. People and where appropriate, their representatives were involved in the assessment and development of their care plans. Care plans contained detailed information about people's needs in relation to their personal care, mobility, skin integrity, nutrition and health. People's personal life histories had also been captured including their occupations, interests and family background. There were clear care plans in place which guided staff on how people's personal risks or specific care needs such as a suprapubic catheter should be managed. For example, people who were at risk of developing pressure areas or at risk of malnutrition had care plans which explained how their risks should be managed. Records showed that some people had been consulted about their end of life care planning and funeral arrangements, however others had declined to discuss their plans. Peoples care plans had been reviewed monthly by staff and reviewed approximately every six months with the person and/or their relative. Relatives and staff told us the six monthly reviews were an opportunity to discuss the person's progress and raise and concerns.

Staff who supported people regularly knew them well and were aware of their care and support preferences. Since our last inspection, the home's units have been reconfigured to ensure people with similar needs were supported together. One relative praised the new arrangement and said, "It's much better. He is happier in a smaller unit." A robust and informative handover took place between each shift and staff were provided with daily handover sheets which contained information about peoples current condition, resuscitation status,

method of communication, moving and handling needs, nutrition and hydration needs, tissue viability and choking risk. The form also recorded if a person was subject to a Deprivation of Liberty Safeguarding (DoLS) authorisation. This meant staff at the beginning of each shift had a clear understanding of people's needs and restrictions.

Staff had taken immediate action when they had observed a change in people's health and well-being. For example, staff had noted that one person had become excessively sleepy on their newly prescribed medicine and requested an immediate review of their medicines by the GP. Family members told us they were regularly updated about the relative's health and care needs. One family member told us they were confident that any changes or concerns would be discussed with them.

The complaints folder indicated that people's complaints had been recorded, and responded to, although the person who had been responsible for the investigation of the complaint had not always recorded their investigation findings and evidence that their suggested actions had been acted on. The manager immediately addressed this by updating the folder with evidence of their investigations and actions. Complaints were reviewed by the provider as part of their auditing process.

The concerns and complaints of people's and their relatives at Ashchurch View were encouraged, explored and responded to in good time. Regular resident and relative meetings were held where they could raise concerns and hear about future events and changes in the home such as the recruitment of staff. Relatives told us they had been sent copies of minutes of relatives and residents meeting if they had been unable to attend. The views of people and relatives were also sought and listened to through day to day discussions. Most people felt their day to day concerns had been addressed. The manager acted promptly and resolved the issue when one relative shared with us an on-going issue about accessing the garden.

Requires Improvement

Is the service well-led?

Our findings

The new manager at Ashcurch View had been in post since May 2017. They had worked at the home for four years and were aware of the provider's policies and procedures and were known and respected by people, their families and staff. The manager was working on an improvement plan to ensure people received the care they required including actively recruiting new staff to ensure people were cared for by staff who were familiar with their needs. Progress was being made to ensure comprehensive systems were in place to improve the quality of the service being provided and provide staff with effective support and development. Under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we will be asking the provider to send us a written report of the action they plan to take to achieve a rating higher than 'Requires Improvement' to support us to monitor the provider's planned improvements.

Ashchurch View has been managed by several managers since the home had opened in 2012. Some staff explained that the changes in the management of the home had impacted on the staff morale and communication across the home but they felt administration and leadership of the home was improving. The manager told us their aim was to drive improvement and promote a positive culture in the home. They recognised that the changes in the management had had an impact on the stability of staff across the home. They said, "Staff retention and recruitment has been my biggest hurdle but I am pleased to say we are getting there. We have interviewed a lot of new staff and are waiting for all their employment checks and inductions to be finalised." Senior staff in the home praised the commitment and dedication of the staff team during the changes in the managers and staff team. One senior staff member said, "Staff have really worked together and the initiative to ensure the residents are being well cared for." Another senior staff member reflected on the changes in the home since our last inspection and had shared with us their concerns about the turnover of staff, heads of departments and the manager. However they confirmed that they felt the home's culture and staffing had improved and said "It's much much better than it was. The home feels settled now."

The manager told us they had been supported in their new role by the regional director, clinical development nurse and representatives from the provider. A deputy manager had also recently been appointed to support the manager and provide additional clinical support to the nursing staff and unit leads. They had transferred from another of the provider's homes and were therefore familiar with the provider's systems and processes. The manager had submitted their application to become registered with the CQC.

Staff told us that communication across the home was improving. A schedule of staff meeting and supervisions were being planned to assist with information sharing and professional development. Staff felt supported and most were confident in the new management structure. We received comments such as "The current manager is very supportive", "We have had a lot of staff changes and had to use a lot of agency staff. The new manager seems to be doing something about it. Things are improving" and "The manager and deputy manager are hands on which is good, I hope they continue." Daily 'stand up' meeting between the manager and heads of departments allowed key staff members to share and discuss events, incidents and specific clinical issues about people and the actions that should be taken. The heads of departments were

required to cascade this information to their own staff team. This ensured that significant information about people and the running of the home was shared.

The manager took an active role in supporting people as well as the running of the home and had a good knowledge about staff and people who lived there. People and their relatives praised the managers and senior staff and felt confident in their abilities to drive improvements in the home.

Quality assurance checks were carried out to monitor the quality and effectiveness of the service being delivered such as infection control and medicines checks as well as regular checks of the kitchen and housekeeping services. Any shortfalls were recorded, acted on and evaluated as part of the quality assurance process. Records showed that regular nutritional meetings had occurred to evaluate whether people received a balanced diet and any risks associated with their eating and drinking such as risk of choking or weight loss was been addressed. The deputy manager also completed a daily report of random checks of the home, people's care and incidents such as people's fluid charts and the actions taken when accidents had occurred. The manager was able to tell us the actions that had been taken when shortfalls had been identified in the auditing system. They understood that any identified areas of concern raised in an audit or via a complaint should have, as a minimum have recorded evidence whether action was taken, when and by whom. However we found that there was not a consistent approach to the recordings of the actions that had been taken. The manager agreed to make the necessary additions that would close the audit or complaint loop to ensure actions had been taken and were effective.

Monthly clinical governance meeting occurred between the manager and senior clinical staff to monitor the nursing care people received. The managers reviewed and analysed clinical occurrences and issues such as people's falls and medicines errors as well as accidents and incidents. The home was also monitored and regulated by the provider's representative. Records showed the home was working on an action plan as a result of their inspection visits.

The manager regularly reviewed the call bell reports and carried out random audits of the response times of staff answering people's request for assistance using their call bells. The manager audited against the call bell procedure and investigated when the staff had exceeded the desired response times. This helped to monitor the staff response times and ensure that staff were suitable deployed around the home.

The maintenance person shared with us the records of the regular maintenance checks, servicing and statutory inspections of the utilities, premises and equipment. They explained that they dealt with the day to day maintenance of the home and any high level maintenance incidents which occurred in the evening or weekends would be addressed by an on call central maintenance team. Regular checks were carried out on the home's fire safety equipment. Records showed that fire drills had been regularly carried out, however it was not always recorded if any action was needed to be taken in relation to the staff knowledge and response to the drills to ensure they were knowledgeable and people were safe. The maintenance person and manager said that they would implement check going forward.

While action has been taken by the manager to make improvements across the home, time was needed to embed and evaluate the success of the improvements. We were unable to assess all aspects of the effectiveness of these actions on this occasion.