Mauricare Limited

Ashview House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on 1 December 2015. This was an unannounced inspection.

Our last inspection took place in April 2015, where we identified multiple Regulatory breaches. We found the service was not safe, effective, caring, responsive or well-led. As a result of our last inspection, this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found

The service is registered to provide accommodation and personal care for up to 22 people. People who use the service have physical health and/or mental health needs, such as dementia. At the time of our inspection 16 people were using the service. Two of these people were using the service for an agreed short period of time. This is called respite care.

The service had a registered manager. However, they were no longer working at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. An acting manager had been appointed by the provider and they had begun the process of registering with us.

During this inspection we found the required improvements had not been made and we identified a number of continued and new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. We are therefore continuing to take enforcement action against the provider.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. This also meant that people's individual care needs and preferences were not always met.

Risks to people's health and wellbeing were not consistently assessed, managed and reviewed and people did not always receive their planned care. People were also not always protected from potential abuse. This meant people were not always kept safe and their welfare and wellbeing was not consistently promoted.

Medicines were not managed safely which meant people did not always receive their medicines as prescribed.

People were not always supported to eat in accordance with their agreed care. This meant people's risk of malnutrition was not always being managed effectively.

When people were unable to make important decisions about their health and wellbeing, the provider did

not always act in accordance with the law.

People's health needs were not consistently monitored and prompt advice from health and social care professionals was not requested when people's needs changed.

There were gaps in the staffs' knowledge and skills that meant some people's specialist needs were not met safely or effectively.

The provider did not have effective systems in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This meant that poor and unsafe care was not being identified and rectified by the provider. The provider could not demonstrate that feedback from people and the staff was used to improve the quality of care. People were reluctant to complain about the quality of care.

The provider did not always inform us of incidents that occurred at the service and pre-inspection information was not completed accurately. This meant we were not always aware of reportable incidents that had occurred within the home.

People were not always treated in a caring manner by the staff and people's privacy and dignity was not consistently promoted. People were not always able to make choices about their care.

Some improvements had been made in the recording of people's care preferences and activity provision. However, further improvements were needed to ensure people's individual preferences and needs were regularly reviewed and met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. There were insufficient numbers of staff to meet people's individual needs and keep people safe.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed, and people were not protected from potential abuse.

People's medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective. People who were at risk of malnutrition did not always receive the support they needed to manage this risk effectively. When people were unable to make important decisions about their health and wellbeing, the provider did not always act in accordance with the law.

There were gaps in the staffs' knowledge and skills which meant people did not always receive safe and effective care. People's health and wellbeing was not always monitored as planned, and staff did not always seek prompt support from health care professionals when people's needs changed.

Is the service caring?

Inadequate

The service was not caring. People were reluctant to approach the staff for help and people told us that some staff were not always kind and caring.

People's right to privacy was not always promoted and people were not always enabled to make choices about their care.

Although we saw caring interactions between people and staff, these positive interactions were often limited to when people needed support with specific care tasks.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Although improvements had been made to the way people's care preferences were recorded. People did not always receive their

preferred care at their preferred time. People were reluctant to complain about their care.

Some people were being supported to participate in leisure and social based activities, but improvements were needed to ensure these met everyone's needs, including the needs of people who wanted to access the community.

Is the service well-led?

Inadequate

Effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This meant that poor and unsafe care was not being identified and rectified by the provider.

The provider failed to notify us of reportable incidents that had occurred at the home.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 December 2015 and was unannounced. Our inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of service.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. The provider had completed a Provider Information Return (PIR) prior to the inspection. 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 used this information to formulate our inspection plan.

We spoke with eight people who used the service and two people who were visiting the service. We also spoke with three members of care staff, an activity coordinator, the cook, the deputy manager, the acting manager and the provider. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing care in communal areas and we observed how the staff interacted with people who used the service.

We looked at eight people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, staff rotas and training records.

During the inspection, we shared our immediate concerns about people's safety and wellbeing with the local authority. The local authority took action to help reduce these immediate safety concerns.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found there were not always enough staff available to keep people safe and meet people's individual needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

People told us there were not always enough staff available to meet their individual care preferences. One person said, "They haven't always got time for me. Sometimes they can't make the time". Another person told us they couldn't access the bath as often as they liked. They said, "I like a bath and a shower, but it's only once a week". Staff told us there were not always enough staff on shift to enable people to bathe at a time of their choosing. One staff member said, "One thing we can't always do is bathe people in an evening. Evenings are a nightmare".

We saw that people didn't always get the support they required when they needed it. For example, one person received their medicines 45 minutes after they requested them. This included a medicine to help control the person's pain. We saw this person waited in the dining room after their breakfast for their medicines. They told us they were in pain. They said, "I normally take my tablets with my breakfast" and, "It takes a while for me to get going in the morning because of [the person's medical condition]". This meant the person didn't receive their medicines when they needed them to help control their pain. We also observed people being told to wait for care and support because care staff were busy. For example, one person requested support to go to the toilet, but a staff member said, "You will have to wait, I'm cooking your tea". This person waited 20 minutes for the support they required to enable them to access the toilet.

People and staff told us that the provider's minimum staffing levels were not always met. Records showed the provider's minimum staffing numbers were not met on 21 of the 30 days in November 2015. This shows improvements had not been made and there were still not enough staff available to keep people safe and meet people's individual needs. This meant the provider continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Risks to people's safety were not always assessed and planned for. Two people who used the service displayed episodes of aggression towards staff. Staff told us and we saw there were no risk assessments or management plans in place to give staff the information they needed to manage the risks associated with people's aggression safely and consistently. We found this had led to staff managing one person's aggression in an inconsistent manner, which placed them and people who used the service at risk of harm to their safety and wellbeing. For example, staff we spoke with told us they would not antagonise this person when they displayed signs of aggression. However the person's care records showed that a staff member

had caused an incident of aggression to escalate because they challenged the person by telling them, 'they must not be rude'. This had caused the person to show increasing signs of aggression and records showed the staff member, 'felt very frightened and feared for their safety'.

Where risks to people's safety had been recognised and planned for, we found that care was not always delivered in accordance with their agreed care. For example, one person required regular repositioning to prevent skin damage. Records showed this did not happen as often as planned. This meant the person could not be assured that the staff were managing their risk of skin damage effectively. We also saw staff assist two people to move in an unsafe manner. This was because their risk management plans were not being followed by the staff. Both people's plans stated, 'Staff must ensure that the service user has been assessed and are able to weight bear to a level sufficient to perform the transfer'. We saw and staff agreed that both people could not stand long enough to move safely. One staff member said, "No, I don't think it's safe, I think they both need hoisting". However, staff told us they were unable to use the hoist with these people as their care plans did not plan for this. This meant there were no plans in place to enable staff to support people to move safely when their ability to move changed.

We found that accidents and incidents were not managed effectively to prevent further incidents or injury. We saw that when accidents and incidents had occurred, people's risks of further incidents were not assessed or managed. For example, records showed and staff confirmed that one person had recently fallen three times. This person's risk of falling again had not been reviewed and staff confirmed no changes had been made to the person's planned care to prevent further falls or injury.

This meant the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was also identified, because people were not consistently protected from risks to their health and wellbeing.

At our last inspection, we found that people were not consistently protected from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

We found that incidents of alleged abuse continued to not always be reported in accordance with the local authorities safeguarding procedures. The agreed local safeguarding procedure is that staff should immediately report safeguarding concerns and incidents to them, so they can consider if any action is required to manage or minimise further incidents from occurring. We found a safety incident affecting one person who used the service had not been recognised as an incident of potential abuse by the staff. As a result of this, the incident had not been reported to the local authorities safeguarding team. We informed the acting manager that the incident needed to be referred to the safeguarding team. They told us, "I didn't know that". This showed the acting manager did not have the knowledge and skills required to consistently identify and report safeguarding concerns. This meant the provider continued to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that medicines were not always managed safely. At this inspection, we found the required improvements had not been made. Effective systems were not in place to ensure medicines were ordered, stored or administered in a manner that protected people from the risks associated with them. For example, one person had not received their prescribed medicine for nine days because there was no stock of the medicine at the home. This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection, we found there were not enough staff available at mealtimes to ensure people received the support they needed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

We saw and staff confirmed that two people who were seated in the dining room needed support to eat at lunch time. However, only one staff member was available to provide this support. This staff member had to keep leaving one person to support the other, which meant neither person consistently received the individual support that they needed. During the evening meal, we saw one of these people did not receive their agreed support again. Their meal was left in front of them uneaten for two hours and 30 minutes before it was removed by staff. This person's care records showed they had lost weight. This meant they could not be assured that their risk of malnutrition was being managed effectively by the staff. Staff told us they found it challenging to meet people's nutritional needs. One staff member said, "There is not enough staff for people's needs. It's hard to prioritise so many different needs. Sometimes I don't know where to begin".

We saw that effective systems were not in place to ensure staff had the knowledge and skills required to deliver safe and effective care. The deputy manager told us and staff records showed some staff had chosen not to attend the training they required to keep people safe and meet people's individual needs. We asked the acting manager and provider what was being done to ensure staff attended training. At the time of the inspection no proactive plans were in place to manage non-attendance of training.

We could not be assured that the training being delivered was of high quality or if staff had understood training. For example, care records showed and staff confirmed they were lifting people from the floor following a fall, using a handling belt. This equipment that was not designed to be used in this way. The Health and Safety Executive states handling belts should never be used to lift a person or take a person's weight. We asked the acting manager about this and they told us, "The trainer told us to do it that way". This meant staff had either been told to use a piece of equipment in an unsafe manner, or they had misunderstood the training.

The evidence above shows there were still insufficient numbers of staff available to support people at mealtimes. The evidence also shows staff did not always have the knowledge and skills required to meet people's individual needs in a safe and effective manner. The provider continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that when people were unable to make important decisions about their health and wellbeing, the provider did not act in accordance with the law. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff told us they were administering one

person's medicines in a 'covert' manner. This meant their medicines were hidden in their food and the person's right to refuse their medicines had been removed. Staff confirmed and the person's care records showed that a best interest decision had not been made to support that it was in the person's best interests to receive their medicines in this way.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the service was not working within the principles of the MCA. The acting manager and staff gave us names of people who they believed were being deprived of their liberty. However, the acting manager could not confirm if DoLS referrals had been made to ensure the requirements of the MCA were being followed. This meant people could not be assured they were being deprived of their liberty in a lawful manner. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health and wellbeing were not consistently monitored. For example, one person's care records showed they should consume a specific amount of fluids per day. Staff were unable to provide a consecutive record of this person's fluid intake and the acting manager confirmed the person's fluid intake was not being regularly monitored by them or the staff. The records we were able to view showed the person regularly did not meet their target fluid intake. No action had been taken to address this as staff had not identified the person was not drinking their target amount of fluids. This meant this person's risk of dehydration was not being effectively managed.

We found that professional advice was not always sought in a prompt manner to ensure that changes in people's health and wellbeing were appropriately assessed. For example, one person's care records showed they were finding it difficult to stand long enough to be supported to move safely. We observed staff assist this person to move unsafely on two occasions and staff told us they felt the way they assisted the person was unsafe. Despite this, advice from a health care professional had not been sought to address this change in the person's ability to move safely.

Inadequate

Is the service caring?

Our findings

People told us that some of the staff did not always treat them in a caring manner. One person said, "You have to have a lot of patience and you have to do what you are told. You can soon land yourself in bother here, you have to be very careful or you get into trouble". Another person told us that staff could be, "A bit bossy". People also told us there were some kind and caring staff at the home. One person said, "They are doing their best". Another person told us, "There are some nice ones".

People told us and we saw they were reluctant to ask the staff for the help they needed because they knew the staff were busy. One person said, "They don't like you pulling the cord. It attracts attention and you are taking them away from what they are doing. They can get ratty and they say, 'what have you pulled that for'?".

We saw that some people did not get the reassurance they needed to promote their wellbeing because staff were not always available. For example, we heard one person shout out questions which were unanswered by staff for 15 minutes. This person was seeking reassurance from the staff to confirm where they were and what they needed to do. The person displayed signs of agitation when their questions were unanswered and the tone and volume of their shouting changed.

People told us they were not empowered to ask for care and support outside of the staffs' work routines. For example, we asked one person if they could ask for a hot drink at any time. They said, "No, it's just not done. We have them at certain times" and, "I fancy one now. I don't know when we are going to get one". This showed this person's individual needs were not met as they didn't feel able to approach the staff for help.

We found that people's right to be treated with privacy and dignity was not consistently promoted or met. One person told us they had a key to their bedroom door which protected their right to privacy. However, we saw two members of staff enter two people's bedroom without knocking.

People told us they were not always offered choices about their care. For example, one person told us some staff made the decision for them about when they should go to bed. They said, "They don't say, 'excuse me would you like to go to bed now'. They annoy me with their attitude". The staff we spoke with told us they always offered people the choice of when to go to bed, but they confirmed some staff did not. One staff member said, "Some night staff moan if people are still up".

Some of the care we observed was delivered in a positive and caring manner. For example, we saw the cook offer people the choice of two meal options and we saw people's meal choices were respected. We also saw some staff spoke to people in a polite and caring manner when they provided care and support. For example, we saw one staff member address a person by their preferred name and ask them if they wanted some help.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that care was not always provided in accordance with people's preferences and people's individual needs were not always met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that some improvements had been made, but more were required.

People told us they had participated in some enjoyable activities, such as; baking and bingo. However, some people told us they continued to be bored at times. One person said, "I get fed up, I do a lot of sleeping". Another person said, "You stew in your own juice". We saw that an activities coordinator had recently been employed and was now working with people to enable them to participate in some leisure based activities. However some people told us they had not yet seen the benefits of this new staff member. One person said, "I have not noticed any difference yet, I have not done anything yet". The activity coordinator said they were getting to know people's activity preferences and were planning on introducing a variety of leisure and social based activities within the home. People told us they had not been enabled or supported to access the community since our last inspection and no plans were shared with us by the staff or provider to show how this need would be met.

People told us they could now choose how they received their personal care. For example, people told us they could choose to have a bath, shower or strip wash. We found that improvements had been made to the recording of people's care preferences. For example, one person's care records showed they preferred their deodorant to be sprayed on their clothes rather than their skin. This person was unable to confirm they had received their care in this manner, but staff demonstrated they were aware of this person's care preferences as what they told us matched what was recorded in the care records. However, we found that care records were not being reviewed with people to check their preferences remained the same. This meant there was a risk that changes in people's care preferences may not be identified and met.

We found that people did not feel able to complain about their care. For example, we asked one person who told us they were unhappy with some elements of their care, if they had made a complaint to the acting manager or provider. They said, "There's no point really, what will be will be". The acting manager confirmed they had received no complaints from people who used the service. Records showed that people were given the opportunity to complain about their care during group meetings. However, records of these meetings did not show that people felt comfortable raising complaints in these meetings.

Staff told us and records showed that meetings had been held with people to discuss activity provision and the quality of meals at the home. We saw that people's feedback about activities from these meetings had been listened to and acted upon. For example, records showed people had asked to play BINGO and people confirmed they had played BINGO.

Inadequate

Is the service well-led?

Our findings

At our last inspection, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

The acting manager and provider had failed to take action to ensure there were enough staff available to keep people safe and meet people's individual needs. Management records showed the previous manager who was still registered with us to manage the home had shared concerns about staffing numbers with the provider. The provider was unable to demonstrate they had listened to or acted upon these concerns as no changes to staff numbers had been made in response to the concerns.

We found that risks to people's safety and wellbeing were not being assessed, monitored or reviewed. For example, action was not taken after a person had fallen to assess or manage the person's risk of falling again. During the inspection we told the acting manager, deputy manager and provider that we had observed two people being supported to move in an unsafe manner. No immediate action was taken to address these safety concerns. This showed the managers and provider were not responsive to safety concerns and people were at risk of harm to their health and wellbeing.

The development needs of the staff were not being effectively managed as some the deputy manager told us and training records showed that some staff had chosen not to attend training sessions. This showed some staff did not recognise the importance of training. We asked the acting manager and provider what was being done to ensure staff attended the training they required to deliver safe and effective care. At the time of the inspection no proactive plans were in place to manage this. The acting manager and deputy manager also told us that no formal competency checks were completed to show staff had understood and were applying their training. This meant the provider was not assessing or monitoring the staffs ability to meet people's needs in a safe and effective manner.

Effective systems were not in place to assess and monitor the quality of care. For example, records showed a check of medicines management had been completed, but no action plan was in place to address the concerns raised as a result of this quality check. This check had identified problems with medicines ordering and recording, but no action had been taken to address these problems. We identified on-going issues with medicines ordering and recording which meant people continued to not be protected against the risks associated with medicines.

Effective systems were not in place to ensure people's health needs were monitored as planned. For example, no one took responsibly to check if people were meeting their daily fluid intake targets. This meant people's risk of dehydration was not being effectively managed.

Records showed feedback from people and staff about the quality of care had been sought using

satisfaction surveys. However, no analysis or action plans were made available to us to show how this feedback was being used to improve quality. We found that issues raised by people and/or their relatives in July 2015 through this survey had not been acted upon. For example, one relative's completed survey stated, 'I feel residents should have a bath when they want one not in a queue or one a week. My relative would like one every other day'. People told us and staff confirmed people were still not assisted to access the bath as often as they would like. This meant we could not be assured that user feedback was being used to improve the quality of care.

After our last inspection, the provider submitted an action plan that recorded the improvements they were going to make to the quality of care. We found that the action plan had not been followed or met. For example, the action plan stated plans would be in place for people who displayed behaviour that challenged, such as aggression. These plans were still not in place at this inspection. This showed the action plan was not effective in bringing about the required improvements to the quality of care. The acting manager told us this action plan had not been shared with them, so they were unaware of the improvements that were required.

We found that some of the information the provider had shared with us in their Provider Information Return (PIR) was inaccurate. For example, the PIR stated, 'The staffing has been increased to ensure that there are adequate staff on the floor to support with the service users current needs' and, 'Staff training has been undertaken to ensure that they have the correct knowledge and skills to assist with current service users residing at the home'. This showed the provider had shared inaccurate information about the service, which meant they had not been open and honest with us.

The provider told us the acting manager had not been interviewed to assess their suitability for the post. The acting manager told us they had no management experience or qualifications. This shows the person's suitability for the position had not been formally considered by the provider.

The above evidence shows that the service was not being managed well. Effective systems were still not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This meant the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not be assured that the provider understood the responsibilities of their registration with us. The provider had failed to notify us of two reportable incidents that had occurred at the home. This included a safeguarding concern and a serious injury. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.