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

Summary of findings

Overall summary

We inspected Ashchurch View on the 15, 19 and 21 November 2018. Ashchurch View provides accommodation, nursing and personal care to 60 older people and people living with dementia. It also provides short term respite for people. At the time of our visit 55 people were using the service. Ashchurch View is located in Ashchurch near to the town of Tewkesbury. This was an unannounced inspection.

We last inspected the home on 6 and 8 September 2017. At the September 2017 inspection we rated the service as "Requires Improvement". We found the provider was meeting all of the requirements of the regulations at that time, however due to changes in the staffing and management teams this had had an impact on the level of engagement people received. At this inspection, we found similar concerns in relation to staffing and the support and stimulation people received. The provider was aware of these concerns and had a long term management plan in place to improve the quality of care people received.

A registered manager was in post at the service, however they had recently started maternity leave. The provider had employed a peripatetic manager to provide day to day management support at Ashchurch View. This manager had just started their employment with the provider. 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.

People did not always receive person centred care or meaningful engagement from care and nursing staff. People went long periods of time without stimulation or support. Care staff did not always feel they had the time to support people with their emotional needs. When people were anxious they did not always receive effective and timely support. People's life histories and interests did not always inform their care plans and the activities they would enjoy.

People, their relatives and staff raised a number of concerns in relation to staffing levels at Ashchurch View. The provider was taking action to address staffing concerns, including staff sickness and staff turnover. During our inspection the provider and manager took effective action in response to concerns raised in relation to the deployment of staff to ensure people were kept safe, this included the implementation of a short term action plan.

Care and nursing staff did not always feel supported and did not feel their professional development needs were met. The provider had plans to implement effective training and supervision support. Staff did not always feel they had the communication they needed to ensure people's day to day needs were being met.

People were cared for in a clean, safe and well-maintained home. The provider and manager carried out effective checks to ensure the service was appropriate for people's needs. Nursing and care staff followed recognised infection control procedures.

People were protected from the risks associated with their care. Care and nursing staff knew how to assist people with their needs and ensure their health was maintained. People's prescribed medicines were mostly managed well, however some nursing staff (including agency staff) did not work to the provider's expectations.
Staff understood their responsibilities to protect people from harm and to report any safeguarding concerns. Staff provided people with choice and worked to protect and maintain their legal rights.

People had access to a good variety of food and drink. Care and nursing staff treated people with dignity and ensured they had their nutritional support and their prescribed medicines. Catering and care staff were aware of and met people's individual dietary needs.

People's relatives felt their concerns and views had not always been listened to and acted upon due to changes within the management team. The provider and manager were aware of this and were making opportunities to effectively engage with people's relatives.

The manager and provider had implemented a leadership and management plan for Ashchurch View. This plan identified long-term goals for the service and initial concerns reflected those found during this inspection. There were effective systems to monitor the quality of service provided at Ashchurch View. However, further time was needed to see if these systems were effective in driving improvements to the care people received.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see some of the action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There had not always been enough skilled staff deployed to meet people's needs, this had impacted on the level of engagement people received.

The risks associated with people's care were managed. People's prescribed medicines were mainly managed well, however some staff did not always work to the providers policies.

The risks associated with people's care were managed. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff did not have access to all the training and support they needed to meet people's needs. Care staff did not always benefit from an effective supervision and appraisal system. The service was addressing these concerns.

People were supported to make day to day decisions around their care. People received the nutritional support they needed. People were supported with their on-going healthcare needs, including rehabilitation to return to their own homes.

Is the service caring?

Good

The service was caring.

Care staff treated people with kindness and compassion when assisting them with their personal care.

People's dignity was promoted and care staff assisted them to ensure they were kept comfortable. People's independence and individuality were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to appropriate activities and stimulation appropriate to their needs.

Where people were at the end of their life they received support to keep them comfortable, in line with their wishes.

People and their relatives told us they had not always felt involved and their concerns and complaints had not always been effectively listened to and acted upon due to changes the management of the service.

Is the service well-led?

Requires Improvement

The service was not continually well led.

The manager and provider had a comprehensive leadership and management plan to address concerns they had identified. These concerns reflected those found at this inspection. Time was needed to assess the effectiveness of these actions.

Care and nursing staff told us they did not always have the communication they required to meet people's needs.

People and their relative's felt there needed to be more management presence in the home.

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 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 15, 19 and 21 November 2018 and it was unannounced. The inspection team consisted of three inspectors. On the 15 November 2018 the inspection team were accompanied and observed by two representatives of the Care Quality Commission to help them understand our inspection methodology. At the time of the inspection there were 55 people living or receiving respite care at Ashchurch View.

We reviewed the Provider Information Return (PIR) which had been completed by the registered manager. 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 took this into account when we inspected the service. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We spoke with four healthcare professionals and one commissioner about the service.

We spoke with four people who were using the service and six people's relative. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 21 staff members including 10 care staff, a hostess, the chef, four nurses, two activity co-ordinators, the manager, a senior home manager employed by Barchester and the Regional Director. We reviewed 11 people's care files. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives felt care and nursing staff kept people safe, although they felt there were not always enough staff available to meet their or their relative's needs. Comments included: "The staff do their best to keep him (relative) safe"; "When the staff are around and their permanent then I think it's safe" and "I think the staff know enough to keep me safe."

At our inspection in September 2017 relatives and staff raised concerns with the inspection team regarding staffing levels in the home, the registered manager and provider informed us of the action they planned to take. At this inspection we identified similar concerns. The provider was aware of these concerns and was taking action to address staff shortages, including managing staff sickness.

People's relatives raised concerns that there were not always enough staff deployed to meet people's needs. Comments included: "There doesn't feel to be enough staff"; "Staffing really concerns me. The retention of staff concerns me, the agency staff just aren't always as good" and "I think the staff are really brilliant, however they're so stretched. They're exhausted and they're leaving. At weekends the staff are hard to find."

Care and nursing staff told us they did not always have time to spend with people to ensure they received their care in a person-centred way. Comments included: "We have a lot of sickness and that has a knock-on effect, we get the care done, make people safe, however we don't have the time we would like to have with the residents"; "We need more staff to ensure the care is person centred" and "Staffing hasn't been great, things are improving, the management are taking action. Residents don't always get the engagement they need."

On the first and second day of our inspection we observed that people on one unit went without any meaningful engagement for significant periods of time, such as an hour. We observed that staff were often task focused and did not spend time with people in the home's lounge. For example, in the afternoon on day one of our inspection 12 people were in a communal lounge, with no support or reassurance from care staff. Two people became anxious, however relatives were present to reassure them as no staff were available. The staffing levels at this time had an impact on the engagement people received. We have reported on the impact on people's personalised care in more detail in the "Is the service responsive" key question.

On the 15 November 2018, we observed people living on Lancaster did not always receive timely and dignified support with their nutritional needs as there were not enough staff deployed to assist at this time. These concerns were echoed by relatives during a relative's meeting on the evening of the 15 November 2018. Following this meeting the regional director ensured an additional member of staff was deployed on this unit to ensure people received the support they required.

During the inspection, CQC received a number of anonymous concerns in relation to staffing and an incident on Saturday 16 November 2018 where there were limited members of staff available due to an unexpected amount of staff sickness. On the 21 November the regional director confirmed staffing levels had been increased in the service and plans were under way to discuss staffing changes with staff and people's

relatives. One relative spoke positively about this change. They said, "The atmosphere in the home is a lot calmer, the residents seem more engaged."

The manager and regional director provided reassurance on the staffing levels deployed at Ashchurch View whilst they recruited more permanent staff and acted on staff absences. They provided us with a copy of their short and long-term management and leadership plans for Ashchurch View which detailed the actions they were planning to take to ensure the quality and consistency of care people received improved. Due to the action the provider was taking at the time of our inspection we have not issued an action in relation to staffing. We will review the progress and impact of the recruitment of the new staff as well as the staffing deployment and levels at our next inspection.

People were protected from the risk of abuse. Care and nursing staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "We raised a concern once. We had to ensure people were safe. We'd always go to the manager first." Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "There are details for us if we need to contact safeguarding or the CQC." Care and nursing staff told us they had received safeguarding training and the manager and provider were in the process of ensuring this training was refreshed.

The provider responded to any safeguarding concerns in accordance with local authority's safeguarding procedures. Since our last inspection, the provider had ensured all concerns were reported to the local authority safeguarding team and CQC. The provider and management staff ensured lessons were learnt from safeguarding incidents and used concerns to improve the service people received. For example, action had been taken following a recent safeguarding concern and near miss. Information on this and on people's nutritional needs and had clearly been recorded and all staff made aware of the support they were required to provide.

People could be assured the home environment was safe and secure. Safety checks of the premises were regularly carried out. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling such as hoists were serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and free from infection. Care and nursing staff wore personal protective equipment when assisting people with their personal care or with their meals. Staff told us this was single use equipment used to prevent the spread of infection. The head housekeeper explained their role and the checks they carried out to ensure the home was clean and free from infection. They informed us they had the equipment and support they required.

People's needs had been assessed where staff had identified risks in relation to their health and well-being. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled them to help people to stay safe. Each person's care plan contained information on the support they needed to assist them to be safe. For example, one person had clear assessments in place for staff to follow to protect them from the risk of pressure sores. There was clear guidance for staff to follow to assist the person to reposition to protect them from the risk of skin damage. Where concerns had been identified by care or nursing staff, this informed the care the person received. For example, care and nursing staff had identified a red area of skin and they assisted the person with repositioning more frequently for a small period of time to maintain the person's skin integrity. Records maintained by care staff showed this person was supported to reposition as stated in their care plan.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. The registered manager and administrator assured where concerns had been identified during the recruitment process, that these were discussed and risk assessments implemented to ensure staff were suitable and people remained safe.

People's prescribed medicines were kept secure. The temperature of areas where people's prescribed medicines were recorded and monitored to ensure people's medicines were kept as per manufacture guidelines. Where people required controlled drugs (medicines which required certain management and control measures) to ensure their wellbeing these were administered in accordance with the proper and safe management of medicines.

People mostly received their medicines as prescribed, however we identified some concerns where nursing staff (including agency staff) had not followed best practice, placing some people at risk of not receiving their medicines as prescribed. For example, on one unit we identified three occasions where people may not have received their medicines as prescribed. One of these occasions had been identified and addressed by a member of agency staff. On this unit we also identified staff had not always followed best practice around dating people's medicine boxes or bottles when opened. Additionally, the recording of support people had received with their prescribed medicines, such as if they refused or if someone did not have their medicine as prescribed. We discussed these concerns with the manager and director of operations who took immediate action to ensure people received their medicines as prescribed. None of these shortfalls had had a negative impact on people's health and wellbeing.

On the two other units, we found nursing and care staff kept an accurate record of when they had assisted people with their prescribed medicines. For example, staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. Nursing and care staff on these units ensured a clear and constant record the support they provided people with their medicines were maintained.

We observed two nurses assisting people with their prescribed medicines. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave the person time and support to take their medicines. The person was in control throughout, offered choice by the staff member and given a drink with all their medicines.

Requires Improvement

Is the service effective?

Our findings

People and their relatives felt the permanent care and nursing staff employed by the provider knew how to meet their or their relative's basic needs, however some relatives felt staff required more support and greater access to training. Comments included: "The permanent staff are really good"; "When we have consistent staff they're really good" and "They help me."

Care staff told us they had the skills to meet people's needs. Comments included: "The care we give is the best possible we can give, given our resources" and "I have the skills I need." One member of staff told us they felt support around training requests were not always forthcoming. They said, "We don't always get the support and time with our professional development." Another member of staff said, "Some staff don't ask for it and they don't always get the development they need. Some staff don't feel valued."

Staff did not always have access to an effective supervision (one to one meeting with their line manager) and appraisal system which enabled them to develop their skills. Comments included: "My last one (supervision meeting) was months ago. All of us have gone without, there has not been enough staff or time to ensure we have them"; "I don't feel I get the support I needed. I had to really ask for it"; "It would help to have more structured support, we don't have that unit leadership" and "We don't always get supervision consistently; however, it is improving."

We discussed these concerns with the manager and regional director. They explained they were aware of these shortfalls. The leadership and management plan for Ashchurch View detailed an action for all staff to receive regular supervision and appraisal meetings. However, time was needed for these actions to be completed. Care and nursing staff did not always have access to the training and support they needed to meet people's needs. These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and nursing staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care and nursing staff understood and respected people's rights to make a decision. Staff explained how they embedded the principles of the MCA into their practice. We observed care staff assisting people to make choices, such as what they would like to eat at lunch and providing choices of hot drinks and snacks.

People's mental capacity assessments to make significant decisions regarding their care at Ashchurch View been clearly documented. For example, two people were able to have their medicines administered covertly as they did not have the capacity to understand the risks to their wellbeing if they refused their prescribed medicines. Assessments had been carried out to see if these people could make a decision. The service worked with each person's family members, lasting power of attorneys and relevant healthcare

professionals, including GPs to discuss the support they could provide in each person's best interests. For each person the GP had identified the medicines which were to be administered covertly and how they should be administered. Care and nursing staff were aware of this information and it was clearly documented in people's care records.

At the time of this inspection a number of people were being deprived of their liberty within the home. 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). The registered manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. Where people were living under DoLS this was reflected in their care plans. Care plans also documented how staff should support people in the least restrictive manner. Where people were under constant supervision or equipment was in place to monitor people's safety and movements, such as sensor mats, this was included in DoLS assessments and relevant mental capacity assessments had been completed.

Care plans provided a clear record of the support people needed with all aspects of their individual needs. This included support around moving and handling, medicines, dementia care, anxiety, behaviours that challenge, pressure area care, diabetes and nutrition. For example, one person's care plan provided clear details on how care and nursing staff should assist them with their emotional wellbeing and anxieties. There was a clear plan in place of how to support the person, and indicators of when the person was becoming agitated. Their plans linked to support staff should provide, including the use of prescribed medicines if required. Care and nursing staff discussed how they assisted this person. One member of staff told us, "Their big trigger is loud music and noise. She doesn't enjoy loud music. So when there are loud activities we try to do something else with them."

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's sensory needs had been identified and staff were prompted to make sure people had access to equipment to ensure their continued independence. For example, checking hearing aids were in working order and glasses were accessible.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, continuing healthcare professionals, occupational therapists and physiotherapists. Additionally, people were supported to attend appointments when required (such as when families were unable to escort their relatives to appointments). People's care records showed relevant health and social care professionals were involved with people's care. For example, care and nursing staff worked alongside a healthcare professional to review one person's personal hygiene needs and the support they required from care and nursing staff. An assessment in relation to catheter care for the person had been provided. We spoke with three healthcare professionals about the service. They spoke positively about the care people received. One healthcare professional told us, "I think they do a good job here, when a patient needs change they arrange for us to come out." Another healthcare professional said, "I think the nurses refer things appropriately."

Where people were at risk of choking or malnutrition, they had been provided with a diet which protected them from these risks such as soft meals and high calorie diets. Care and nursing staff knew which people needed this support. For example, one person was assessed as being at risk of choking and malnutrition. There was clear guidance in place for staff to support this person regarding their meals ensuring they were all soft and fortifying their food and drink to meet their nutritional needs. Care staff confidently discussed how they assisted this person to support them to maintain their health and wellbeing.

People and their relatives mainly spoke positively about the food and drink they or their relatives received in the home. Comments included: "I think the food is good, he really enjoys his food, often has two soups and two sweets as well as their main meal" and "The food always looks good and presentable." Care staff supported people to have access to food and drinks throughout the day. Drinks were in communal areas and people's rooms and were refreshed daily or more often if required.

People were comfortable in their environment and did not appear agitated when walking around the home. The home was well decorated with a range of spaces for people to use, including quiet lounges. The dementia unit had a balcony conservatory area where people could enjoy an outdoor space, including raised potting plants to enjoy gardening.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the caring nature of staff employed at Ashchurch View. Comments included: "I think the care staff do their best, we just need more of them"; "The permanent staff are really good" and "Generally the staff are kind and caring."

People enjoyed positive relationships with care, nursing and other staff. On the last day of our inspection, when staffing levels had been increased, the atmosphere was often friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner. We observed when care staff assisted people with their needs they did so in a kind and compassionate manner. Staff promoted people's choices and respecting people's wishes. For example, one person enjoyed a pleasant conversation with a member of staff, the staff member said, "I see you had your hair done. You look lovely. It really suits you." The person enjoyed talking to the member of staff.

On one of the home's units, people engaged staff and were comfortable in their presence. They enjoyed friendly and humorous discussions between each other. People talked to each other and clearly respected each other and were observed talking and laughing with each other. We observed people enjoying their lunch together and engaging in polite conversation, asking who the inspectors were and what they were looking at.

People were supported to maintain their personal relationships. For example, People and their relatives told us that visitors could visit at any time and there were no restrictions in the visiting times. The service worked with people's families and were aiming to improve communication with people's relatives to ensure they were involved in any changes. One relative told us, "I can come everyday, I like to have lunch with (relative). The staff are supportive of this." Another relative said, "The unit manager is really approachable."

People's dignity was respected by care staff. For example, when people were assisted with their personal care staff ensured this was carried out in private. People living at Ashchurch View felt they were treated with dignity and respect and their wishes were respected. We received comments such as: "The staff make sure they get their care in private" and "I think they treat (relative) with dignity and respect when they assist them."

Care and nursing staff told us how they ensured people's dignity was respected. All staff members told us they would always ensure people received personal care in private and would ensure they were never exposed. Comments included: "We always make sure personal care is carried out in private. Make sure the door is closed and make people comfortable" and "We respect this is the residents home. We make sure people are comfortable and that their room is their space." One person's relatives praised the care staff for the way they assisted their relative with their personal grooming needs and said, "I am happy that they always look clean and respectable, this is important."

People were able to personalise their bedrooms. For example, people had decorations or items in their bedroom which were important to them or showed their interests. For example, one person's room

contained photos of their family and people who were important to them. People had memory boxes next to their bedroom doors, these contained pictures and mementoes which were important to them.

People where possible were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes regarding their end of life care. This person had also made a decision to refuse resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans. Other people had completed advanced care plans which documented how they wished to spend their final days and what things were important for them to have at the end of their life, such as family and specific music. Additionally one person had clearly documented who they wished to be involved in their care and how information should be provided to them; this provided the person with comfort knowing that their information would not be shared without their permission.

Requires Improvement

Is the service responsive?

Our findings

People did not always have access to activities and stimulation which were personalised to their individual needs and preferences. People's care plans contained life histories, including people's hobbies, work history and interests. However, whilst this information had been sought and recorded it had not informed their activity or engagement care plans. People's care plans did not provide guidance for staff to support people in the activities that they enjoyed or were appropriate to their needs and abilities.

There were no continuous records of the activities provided to people within the home. A record of activities for five people had not been recorded since June 2018 we could therefore not be assured that they had been given regular opportunities to enjoy one to one and group activities. There were no documented evidence or record of individual one to one activities available to people within the home since this time. People who therefore could not engage in the planned group activities might not have access to stimulation and engagement personalised to their needs.

People's relatives told us there was not always enough stimulation or engagement to meet their or their relative's well-being needs as there were not always enough staff present to meet their needs. Comments included: "Some days there just isn't anything going on, you can't find the staff"; "The residents are just left there for long times" and "Staff don't have the time to give people the engagement they need."

We observed that people often went periods of time from half an hour to an hour without engagement from staff. People either spent their time in their own bedrooms, in each unit's lounge or walking around their units. Often people were withdrawn or asleep as there was a limited amount of engagement from care staff. This meant sometimes people went without the support they needed and their choices were not always acted on. For example, one person was offered a cup of tea when other people had also been given a cup. The person needed full assistance from staff to have this drink. We observed the person was offered a drink, which they responded positively to, however the person did then not receive the drink and after 20 minutes was supported to go to the dining room. At this time staff then became focused on ensuring people had their meals.

People did not always receive support when they were anxious. For example, during one afternoon we observed two separate occasions where people became anxious, however there were no staff available to assist people. Two people were shouting out and their relatives provided them with reassurance to calm the situation. One person walked into the lounge and had a negative interaction with another person. The first person lashed out, however missed. One relative told us, "The pressure is on us (relatives and visitors) to monitor people in the lounge." Following this interaction we informed the manager and regional director of the concern.

People were supported by staff who did not always know their needs or preferences. Due to the use of agency at the service, there were sometimes staff on duty who did not know people's needs. For example, if a person was visually impaired, or what people preferred to eat or drink. We observed on one lunch meal that people were provided food and drink without a choice to their preferences. For example, drinks on

people's tables had already been poured and placed without people being offered a choice.

We discussed these concerns with the manager and the operations director, who were aware of some concerns regarding activities and engagement from care staff. A new activity co-ordinator team had recently been recruited and actions in relation to activities had been identified as part of the services management and leadership plan.

People did not always benefit from person centred support from care staff. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new activity team had been recruited, who had plans to provide person centre activities which met people's needs, abilities and preferences. The activity co-ordinator told us, "We're here to work with people. We're going to get staff involved, whether they're maintenance or housekeeping. We have things set up for January 2019, such as the memory man. We've got music and movement in too. We're focusing on community engagement, linking with (local sheltered housing complex) and getting residents out in the community." The activity co-ordinator also told us they had got in contact with a local news outlet to cover nominations two of the catering team had received.

We observed a music and movement session for people on the second day of our inspection. The activity co-ordinator arranged for one person to play piano. The activity co-ordinator explained how they were focusing on the interests and life histories of people to provide activities which were meaningful and engaging.

People's relatives were informed of any changes in their relative's needs. For example, one person's relative told us staff always kept them updated and informed of their relative's needs and wellbeing. They said, "The permanent staff tell us when things change, they keep us updated." People's care records showed where staff had contacted family members to ensure they were updated on their relative's well beings.

Staff responded well to ensure people's health and wellbeing were maintained. For example, care and nursing staff had identified complications with one person's healthcare needs. They raised concerns, however were not happy with the initial response they received. They followed this through with permanent nurses and the management of the home to ensure effective action was taken to ensure the person's health and wellbeing was maintained. Care staff were aware of the person's needs and informed the inspection team.

People were supported at the end of their life and to maintain their comfort. One person was starting to receive end of life care and anticipatory medicines had been prescribed by the person's GP. This person had a clear end of life care plan detailing their preferences regarding their care and support. The focus of this was to ensure people's end of life care was personalised to their preferences and needs. One visiting healthcare professional spoke positively about the end of life care people received at Ashchurch View. They told us, "The end of life care here is particularly good. They are really responsive and they ensure the medicine and support is available."

People knew how to make a complaint if they were unhappy with the service being provided. Relatives felt that due to the changes in management they were unsure if their concerns had been responded to effectively. The management were aware of this and were taking action to ensure people and their relatives views were sought. One relative told us: "I'm worried if concerns are communicated throughout the service." Another relative said, "The unit leader is really approachable. The other managers are around, however it doesn't always feel like they take things onboard." The manager and regional director spoke about their plans to develop their relationships with people and their relatives to ensure they were comfortable with

raising their concerns.

The manager kept a record of complaints and compliments they had received about the service. They had clearly investigated these complaints and discussed the outcomes with people and their relatives. For example, one person complained about staffing arrangements within the home, the previous registered manager had documented the action they had taken to deal with the complaint and ensure concerns weren't repeated.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection, a peripatetic manager had been appointed to run Ashchurch View whilst the registered manager was on maternity leave. 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 manager was being supported by a senior registered manager (a registered manager employed at another of the provider's services) and the regional director.

The manager and regional director had a leadership and management plan for Ashchurch View which took into consideration shortfalls they had identified through audits and quality assurance checks. This was a detailed plan focused on improving the quality of care people received. Immediate focus on developing a management team and recruiting a full staff team. The plan also covered areas such as staff training and supervision, people's care, medicine administration and mental capacity records and people's social needs. Each action was set against a responsible person and a record of the actions people taken, for example, the start date of the peripatetic manager had clearly been recorded. The leadership and management plan had been updated to take into account concerns found at the first day of our inspection, a relative's meeting and any other concerns received, such as staff raising concerns around their morale and access to staff supervision. This plan enabled the regional director and peripatetic manager, as well as regional director.

This plan had only recently been started and therefore, whilst concerns we had identified at this inspection had been identified by the provider, time was required to implement and sustain these actions before improvements could be identified. Additionally, while actions had been implemented, the service was not meeting all of the relevant regulations at this time.

The peripatetic manager and the regional director were making more opportunities to engage people and their relatives, to ensure there was improved communication and trust. On the first day of our inspection a relatives meeting had been arranged for the manager to meet people and their relatives and seek their views. This meeting was used to discuss staff changes and enable relatives to express their views in relation to staffing. For example, relatives raised concerns around staffing at mealtimes and the regional director ensured immediate action was taken. Maintenance and activity changes had also been discussed to ensure relatives were aware of all current events. The manager and regional director informed us they were increasing the frequency of these meetings to help promote increased communication with relatives.

Nursing and care staff spoke positively about recent changes, however discussed the need for consistency and stability within the service, particularly in relation to staffing, communication and the management of the home. Comments included: "We need stability at this time, there has been a lot of changes and we've been left feeling a bit unvalued"; "A lot of staff are leaving. While agency help, they're not permanent staff. We need more staff" and "I think we need more support and recognition." People's relatives also expressed their worries in relation to staff turnover. One relative said, "We have good staff, I'm just worried they are getting flogged." Another relative told us, "I think staff burnout is a problem." Staff and relative feedback was

passed back to the manager and regional director, who provided reassurance that they would ensure staff would be supported during this time. They were also planning on carrying out exit interviews to identify the reason staff were leaving to enable them to take remedial action.

Care and nursing staff told us that they did not always feel they had effective communication throughout the home. Some staff raised concerns that information was not always effectively passed between shifts to ensure all staff had the current information. The manager and regional director were aware of this concern and were taking immediate action to ensure that all staff had access to the information they required to meet people's needs.

The manager and regional director were implementing new systems to aid improvement in the record of the care and support people received in relation to their healthcare needs. Care and nursing staff spoke positively about these changes. One member of staff told us, "It is making life easier and we can focus on assisting people." People's care plans were being reviewed and updated to ensure staff and healthcare professionals could easily access information. Two healthcare professionals spoke positively about accessing people's care plans and gathering the information they need. This helped to ensure people's care plans were current and accurate and reflected people's healthcare needs.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care which was personalised to their needs and wellbeing. People did not receive effective stimulation and engagement from staff. Regulation 9 (1)(a)(b)(c) 3(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Care staff did not always receive the training and support they required to meet people's needs. Regulation 18 (1)(2)(a)(b).