Mauricare Limited

# Ashby Lodge Residential Home

**Inspection report**

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| 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? | **Good** |

## Overall summary

The inspection took place on 30 December 2014 and was unannounced.

There were no breaches of the legal requirements at the last inspection in March 2014.

Ashby Lodge provides accommodation and personal care for up to 22 people. The home is on the main Leeds Road in Outwood and is close to local shops and amenities. There were 20 people living in the home when we visited.

The service had a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

# Summary of findings

Ashby Lodge was homely and welcoming with a happy atmosphere. There were good relationships between staff and people who lived in the home. Staff were kind and caring with high regard for people's individual needs.

People's dignity and rights were promoted and they were treated with respect by staff who understood their individual needs. Staff involved people in their care, supported their independence and promoted person-centred care.

The registered manager had a sound understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff worked well together and communication was effective to ensure people's needs were met. Staff were recruited appropriately, skilled and knowledgeable about people's needs and training was ongoing to support staff in their role.

Care records provided sufficient information for staff to be able to support people's individual needs safely. People engaged in sufficient activities of their choice.

People and their relatives praised the service and the staff. Visiting professionals said communication was effective to ensure people's needs were met.

Medication was not always given to people as stated on their prescriptions, which meant people may not have received their medicines appropriately.

Systems to monitor and review the quality of the provision were in place and the registered manager was involved in people's care delivery, maintaining an overview of the service. Improvements to the quality of the service had been made since the last inspection. Not all quality checks were rigorous enough to ensure practice was sound, such as with audits of medications.

Improvements to the quality of the service and the premises had been made since the last inspection. However, improvements were required in the kitchen area with regard to electrical sockets, appliances and food safety.

You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## 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. Although people told us they felt safe, we saw medication administration procedures were not as robust as they should have been to ensure people's safety.

People's individual risk assessments were known by staff to enable them to promote safe care.

Aspects of the kitchen premises, equipment and food storage were not maintained safely.

Recruitment procedures were sound and staffing levels were appropriate for people's needs.

**Is the service effective?**

**Good**

The service was effective.

People were given choices in the way they lived their lives and their consent was sought in line with legislation and guidance. The registered manager had a sound understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff had regular access to relevant training to enhance their role. Staff had regular supervision meetings to support them in caring for people's needs.

People's individual dietary needs and choices were suitably catered for.

**Is the service caring?**

**Good**

The service was caring. Staff demonstrated positive caring relationships with people and treated them as individuals, with kindness and respect.

Staff listened patiently to what people had to say, made them feel valued and important and responded to their needs quickly and thoroughly.

People were encouraged and supported to make their own decisions in their day to day care and their choices were respected. People's visitors were welcome to come at any time they chose.

**Is the service responsive?**

**Good**

The service was responsive. People's individual care records contained sufficient up to date information for staff to provide appropriate care.

People regularly participated in residents' meetings in which they expressed their views and made their wishes known to staff.

People and visitors said they felt they had nothing to complain about but they were confident to raise any concerns with staff and the manager if they needed to.

# Summary of findings

People had sufficient activities of their choice.

**Is the service well-led?**

Good

The service was well led. Systems were in place to regularly monitor and review the quality of the service. Where systems needed to be more robust, the registered manager agreed to address this.

The registered manager was involved in the delivery of people's care and knew the individual needs of the people in the home.

The registered manager's office door was open and people, staff and visitors had open access to discuss any issues.

# Ashby Lodge Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 30 December 2014 and was unannounced.

The inspection team consisted of three ASC inspectors. Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with 12 people who used the service and two relatives during our visit. We spoke with the registered manager, a visiting district nurse, a pharmacist and three staff. We observed how people were cared for, inspected the premises and reviewed care records for three people. We also reviewed documentation to show how the service was run.

Requires Improvement

# Is the service safe?

## Our findings

We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. However our inspection revealed there to be some shortfalls in the management of medicines.

People told us they felt safe at Ashby Lodge. One person said: “It’s safe here alright, home from home to me”; another person said: “I feel safe to know there’s someone there looking out for me.” However, we found procedures for administering medication were not always properly followed to ensure medicines were given as prescribed.

Medicines were administered to people by appropriately trained care staff. No person at the home had been found to have the mental capacity to self-medicate. We spoke with a visiting pharmacist who told us they had no concerns about the supply and disposal of medicines in the home. The pharmacist said there was good communication between themselves and the registered manager to make sure people had the right medicines.

During our visit we checked inside the medication trolley. We saw it was kept in an orderly manner. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in a monitored dosage system. We saw that external topical preparations, oral nutritional supplements and dressings were appropriately and safely stored.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CD’s). We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. We saw that the storage facility for CD’s conformed to legal requirements.

We saw records of medicines (including controlled drugs) that had been disposed of, or were waiting for disposal. Medicines for disposal were stored securely in a tamper-proof container within a locked room until they were collected.

When PRN (as required) medication had been prescribed we saw staff had recorded whether the medication had been given or not. We saw that all PRN medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures.

We looked at medication administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines. We checked the quantities of medicines not dispensed in the monitored dosage system. We found that quantities of medicines supplied were recorded on the MAR thus making it possible to audit medicine administration. We found that on two occasions quantities had been recorded but not accurately. In one instance the quantity of medicine recorded was two less than in stock and in the second instance two greater than in stock.

We saw that specific instructions for the administration of medicines were commonly not being adhered to. We found that one person had been prescribed antibiotics to be administered four times a day, yet since prescribed, the antibiotics had been administered only three times a day. On three occasions we saw medicines administered to people after breakfast when the instruction was to take the medicine between 30 and 60 minutes before food. On another occasion we saw a different medicine administered over an hour after breakfast when the instruction was to administer before breakfast. Finally we saw a medicine administered to a person after breakfast when the instruction was to take the medicine on an empty stomach.

These issues demonstrated that whilst there was a medicines policy in place and staff had received training this was not being translated into safe practice. This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines.

Staff we spoke with told us the signs that would make them concerned about a person’s safety and welfare. They

Requires Improvement

# Is the service safe?

described the procedure to follow to ensure a person was safeguarded against abuse or neglect and they were confident to follow the whistleblowing procedure should they discover poor practice.

We saw there had been some improvements to the maintenance of the premises since our inspections in the previous year. We detected some odours in communal toilets, although staff attended to these frequently. The floor surface had been replaced in the corridor areas since our last inspection. The maintenance staff member was actively working to complete minor repairs and maintenance on the day of our visit and there was a log book with identified repairs. However, in the kitchen area we identified some areas of concern in relation to premises, equipment and food safety. For example, there was a lack of working electrical sockets in the kitchen, which meant there was only one double socket available to service several appliances. If staff needed to boil the kettle whilst other cooking appliances were in use, the cooking of food had to be interrupted.

We saw there were two domestic kettles, but only one of these had a wire long enough to reach the electrical socket, which meant only one small kettle was in use. This resulted in delays to staff being able to make everyone a hot drink at a time they requested one as this kettle was not adequate to serve all the people in the home. There was no dishwasher in place and staff were required to wash all eating utensils by hand, without any checks made to ensure water temperatures were sufficiently hot enough to kill any bacteria. Staff told us the provider had removed the previous dishwasher but this had not been replaced for some time.

We saw staff used a food temperature probe, but this was taped up with a blue plaster as it was broken. Staff told us they had requested a replacement but this had not yet been supplied. We saw where people had not eaten their meals, they were left to cool on the work surfaces in the kitchen; staff told us they would be heated later should people decide they wanted them. However we saw one meal was still left on the work surface several hours later, as were some uncovered desserts.

We referred our concerns to the Environmental Health team following our inspection.

Staff were knowledgeable about individual people's abilities and the individual risks to people. Staff spoke with people and reassured them about their safety as they supported them in their care tasks. Staff were aware of what to do in the event of an emergency and we saw each person had a personal emergency evacuation plan in place.

There were sufficient numbers of staff on duty to meet people's needs and people did not have to wait for assistance. People we spoke with said staff were attentive and they responded promptly if they used their call system. The relatives and visiting professionals we spoke with said they had no concerns about staffing levels based on their observations when they visited the home.

We looked at two staff files and saw recruitment procedures had been robustly followed with all checks made prior to staff working with people in the home. We spoke with a member of staff who had recently been employed and they told us they were thoroughly vetted before they were allowed to start work.

Good

# Is the service effective?

## Our findings

Throughout our inspection we saw that people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff accurately interpreting body language to ensure people's best interests were being met. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. One person at the home was subject to DoLS and a further application had been made. Discussion with the manager demonstrated a good understanding of the legal framework in which the home had to operate.

We saw that on one occasion a best interest decision had been made were a person lacking in mental capacity had been unable to make a particular major decision and hadn't made suitable plans in advance. The person had no relatives to support them in making the decision. Through the Independent Mental Capacity Advocate Service an Independent Mental Capacity Advocate (IMCA) had been appointed. The role of an IMCA is to support and represent a person who lacks capacity in making an important decision, and who has no-one, other than paid carers to support them. We saw from records that a mental capacity assessment had been carried out by a consultant psychiatrist and a principle social worker. A best interest assessment had been completed by a social worker and a circumstances report had been completed by a community psychiatric nurse. To complete the process the IMCA had submitted their assessment. We saw the person concerned was present at the best interest meeting as was the registered manager of the service. The outcome of the meeting was communicated verbally by the psychiatrist and followed up in writing.

Staff training had been completed and an overview was maintained on the training matrix which identified when refresher training was due for each member of staff. There was a notice displayed for staff about forthcoming training which demonstrated training opportunities were ongoing. Staff we spoke with told us they completed all mandatory training, but would like additional training to enhance their skills in areas such as care planning. The registered manager told us staff were able to discuss training needs in supervision meetings and confirmed these were held at regular intervals. We saw the supervision planner which confirmed this. Staff we spoke with told us they had supervision meetings, although could not recall when their last one had been.

We saw people enjoyed their meals overall. One person told us they 'get plenty of food' and another told us the 'food is good'. People were given time to eat at their own pace and were asked whether they had had enough to eat. Staff were on hand to assist people in the dining room if they needed support and appropriate use was made of plate guards and aprons. Staff were observant when one person struggled with swallowing their food and responded promptly to offer assistance. We noticed two people who chose to stay in their rooms were served their lunch some time after everyone else. One person told us they 'felt abandoned'; however, we saw staff attended promptly when we discussed this with them and assured us the person had been visited by staff several times.

People were offered regular drinks, although not all people wanted cold drinks and some people said they would prefer tea. We noticed the availability of hot drinks was delayed for some people due to there being only one small kettle in operation, which meant some people did not have their choice of drinks when they wanted them.

We spoke with the cook who was clear about people's dietary needs and their personal preferences. We saw menus were varied and contained daily fruit and vegetables. There was a fruit bowl accessible to people in the dining room. The cook had spoken with people and gained feedback from them about the meals and what foods they enjoyed.

Nutritional risk assessments had been completed which identified if a person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. To protect people from

Good

# Is the service effective?

the risks of receiving inadequate nutrition and fluids, staff recorded and monitored people's daily intake. Additionally, records showed that people were being weighed regularly in accordance with their care plans.

Records showed that arrangements were in place that made sure people's health and social welfare was protected. We saw evidence that staff had worked with various agencies and made sure that people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, psychiatrists, community mental health nurses, opticians and dentists. One person we spoke with and their relative confirmed the staff always referred to their GP if they had any concerns about their health. We spoke with a district nurse who told us staff were proactive in seeking advice and receptive to advice given to ensure people's health needs were met.

# Is the service caring?

## Our findings

Staff were very kind and caring in their approach to people and it was evident there were warm and supportive relationships in place for people's care. Staff communicated with people at face to face level and used positive expressions and gestures to acknowledge people and show they were valued. For example, we saw staff touch a person's hand to reassure them, wait patiently when a person was speaking and repeat information a person had forgotten.

People spoke positively about the staff. Comments included: "They're lovely, nothing is too much trouble", "They look after me well", "Staff are friendly", and "They really care about me". Staff we spoke with told us how much they enjoyed spending time with the people who lived in the home.

Relatives we spoke with said staff knew their family members well and one relative said they saw 'the same faces all the time' illustrating staff consistency for people's care.

We saw people were nicely dressed and staff had taken time to ensure they were assisted with personal grooming where necessary. We saw gentlemen were smart and shaved and ladies wore personalised outfits and jewellery, with handbags if they wished to carry them. Staff paid people compliments on their appearance, which made people smile. We heard happy banter and laughter in the home and there was a caring atmosphere.

Visitors to the home described it as 'homely' and 'welcoming' and our observations confirmed this. One visitor told us: "The home always smells of dinner or washing" which they said created a homely feel. Visitors told us they were welcome at any time, without informing staff in advance. One visitor told us staff always made them feel included and involved and offered them a cup of tea.

Staff were aware of what mattered to people and they helped them with individually important things, such as ensuring replacement batteries were available for a person's hearing aid and helping another person locate their preferred seat in the lounge. Where people had difficulty communicating verbally, staff appropriately interpreted non-verbal cues to establish what people wanted to say.

We saw two care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

We saw people's bedrooms were personalised with items of individual importance, such as photographs, ornaments and pictures. One person's room only had net curtains and we were concerned this may impact on their privacy. The registered manager told us new curtains were on order and the person told us 'something is being done about it'.

# Is the service responsive?

## Our findings

We looked at three care plans that had been developed for each person. They were person-centred to document people's wishes in relation to how their care was provided. The care plans evidenced how people liked to spend their time and how they liked to be supported. The plans also showed what people or relatives told staff about what provoked their anxieties and behaviours that may challenge the service.

Care planning was developed out of a pre-admission assessment. The profile derived from the pre-admission assessment covered such issues as mobility, continence, eyesight, hearing, memory, eating ability and a falls history. The pre-admission assessment also recorded primary and secondary diagnoses and a list of all current prescribed medicines. The care plan focussed on the need to maintain a safe environment and promote personal independence and dignity.

One of the care plans was for a person whose admission had resulted from a fall. Detailed care needs had been gathered from the hospital and translated into a care plan. We saw that particular mobility needs had been met with detailed records of daily activities being kept. We also saw risk assessments had been carried out with the person's wishes being adhered to. For example, the staff sought to mitigate risk of falls during the night by placing a pressure mat by the person's bed. The person had asked for this to be removed and replaced with a call buzzer. This demonstrated that the staff were letting people make their own decisions even when that decision may not be the best course of action.

We saw that all care plans were subject to monthly review. Evidence gathered suggested that incidents and changes in care needs were reflected in the review process.

We observed, in a communal area, the care of a person living with dementia who was showing a lack of inhibition. We spoke with staff who demonstrated an understanding that this behaviour may be because of failing memory, general confusion or specific damage to the brain. We saw staff trying to discourage the person tactfully and trying to distract their attention. When this failed the person was gently taken to their room for a time. We looked at the person's care plan which showed the staff were adhering to an agreed course of action. We saw also that psychiatrists and community psychiatric nurses were involved in the development of a bespoke care plan and an appropriate medication regime.

Staff were aware of people's social histories and how they liked to spend their time. The registered manager told us there were difficulties recruiting an activities co-ordinator, although we saw there were some arranged group activities on different days, such as 'exercise to music'. People told us there had been music sessions over the Christmas period. We saw little activity took place in the main lounge area and people spent time watching television, looking out of the window or sleeping. People told us they were not bored. One person said: "I quite like to just sit"; another said: "I call it resting my legs". We saw some people chatted with one another and we saw one person particularly liked to sit in the registered manager's office, where comfortable seating was positioned by the window. There was a quiet lounge which was accessible to people although we saw this was not used. The registered manager told us people gravitated towards the main lounge and dining area if they wanted to spend time with others. Some people chose to watch television in their own rooms or listen to music.

Staff respected people's wishes and choices and there was strong emphasis on enabling people to make their own decisions. We spoke with one person who told us they preferred their own company and wanted to stay in their own room rather than socialise with others. Staff told us they always included this person in any discussions about activities and invited them to come to the lounge to be with other people, but respected their choice not to.

The registered manager told us there had been only one complaint, which had been addressed through the safeguarding procedures. She told us this was taken very seriously as staff endeavoured to provide a high standard of care at all times. People told us they knew how to complain if they wanted to and staff we spoke with told us they would support people in this process if necessary. Relatives said they were confident that if they raised any concerns these would be dealt with immediately.

We saw evidence of regular residents' meetings, which were well attended and gave people the opportunity to have a say in how things were run. For example, the last meeting minutes in December recorded what

# Is the service responsive?

arrangements people wanted to be made for the Christmas festivities. Thank you cards were displayed in the entrance and there were many positive comments and compliments given to the staff.

# Is the service well-led?

## Our findings

We saw the registered manager was visible and fully involved in the service. We saw they were engaged with people in their care and support and supported care staff in their work, undertaking any relevant tasks in support of the team. For example, we saw as the cleaner was absent on the day of our visit, the registered manager helped out with routine cleaning tasks as necessary. The registered manager's office door was open so people could come in and out as they wished and we saw people, staff and visitors did so throughout our inspection. This demonstrated an openness and approachability.

People and visitors told us they were comfortable to discuss any matters with the registered manager or any member of staff. Visitors and staff we spoke with told us the provider was also frequently present in the home and knew the people who lived there. We saw newsletters had been regularly produced and the most recent one was displayed on the notice board for people to see. It included details of forthcoming events and people's birthdays.

We saw regular quality checks had been carried out, such as for cleaning and maintenance of equipment and premises. Documentation was available to show where external companies had been brought in to carry out repairs and maintenance. Documentation we looked at was not always specific to Ashby Lodge, such as some generic risk assessments.

Although we saw evidence that audits of practice were carried out by the registered manager, we found these were not always as robust as they should have been. For example, the medication audits should have picked up our findings that staff were not following current NICE (National Institute for Clinical Excellence) guidance 2014 with regard to managing medicines in care homes.

This recommends a new medication record 'should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used'. The senior care worker we spoke with said there had been no check for accuracy by a second member of staff. We discussed this with the registered manager who told us she would give prompt consideration to this.

Accidents and incidents were recorded and reported appropriately. The registered manager summarised and monitored these to establish whether there were any trends or patterns and where necessary made adjustments to people's risk assessments or care plans.

The registered manager responded positively to recommendations made by other agencies, such as environmental health and infection control teams. She told us the quality of the service had improved since the last inspection and this was evident in our findings.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br><br>People who used services and others were not protected against the risks associated with the administration of medicines as staff did not always follow the instructions on each person's prescription. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.