Ashdown Care Limited

Ashdowne Care Centre

Inspection report

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Date of inspection visit:
27 July 2021
02 August 2021

Date of publication:
23 August 2021

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Ashdowne Care Centre is registered to provide accommodation with nursing or personal care, for up to 60 people. There were 58 people using the service on the first day of our inspection.

The service is in the town of Tiverton. It comprises of two detached, two storey buildings linked by a corridor. The home is divided into two units, one in each building, Ashdowne and Pinnexmoor. The Ashdowne unit is primarily used for older people with physical disability and the Pinnexmoor unit is for older people with dementia or a mental health need. Each of these units has its own staff team, communal spaces and secure outside garden for people to use as they choose.

People's experience of using this service and what we found
People felt safe living at the service and relatives felt confident people were safely cared for. Staff had received safeguarding training and demonstrated an understanding and awareness of the different types of abuse. Risks to people's health and safety had been identified.

Improvements had continued to ensure there were enough staff on duty at all times. Staff sickness had improved but continued to have an impact which put pressure on other staff. The registered manager had recruited a full care staff team and was working to improve staff sickness further.

Staff had been safely recruited. Staff new to the service completed a period of induction and the providers induction pack.

Fire safety was well managed. Regular checks of the environment and servicing and maintenance of equipment was carried out to identify and minimise environmental risks.

Staff had received training and were following up to date guidance in infection prevention and control, to minimise risks to people. Staff used personal protective equipment (PPE) correctly and in accordance with current guidance to minimise cross infection risks to people.

The provider was facilitating visits for people living in the home in accordance with the current guidance. Although some people and relatives were not always clear about the government's guidance and the visiting arrangements at the home.

Medicines were safely managed. All staff that were administering medicines had received training around the safe use of medicines and their competency had been assessed. A recent pharmacy report had raised no significant concerns.

People's physical and mental healthcare needs were being well-monitored to recognise any signs of deteriorating health so action could be taken. Staff had the skills and knowledge to deliver care effectively.

People and relatives mostly told us the food at the service was good and they were offered choices. Improvements were needed to make sure the mealtime experience was a pleasant social occasion for all people at the home. This was being addressed by the management team.

The provider had continued to develop and extend the service and had a programme of refurbishment to redecorate and upgrade.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests.

The service was well-led by a registered manager who had a dual registration with CQC and managed two services for the provider. They were supported by the provider's operations manager, two-unit leads, nurses and team leaders. They had made improvements since starting at the home but were facing additional pressures due to the pandemic and staff sickness. Staff spoke highly of the registered manager, however some staff felt they needed to be at the home more and could improve their communication. The registered manager was very responsive to this feedback and said they would work to improve their communication.

Quality assurance and monitoring systems were in place to help drive improvements at the service.

Why we inspected
We received concerns in relation to staffing levels, staff training and the management style and culture. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed following this focused inspection and remains good.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our effective findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	**Good**

Ashdowne Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One of these joined us at the service and spoke with people and relatives and the second remotely contacted relatives to ask their views about the service.

Service and service type
Ashdowne Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. They have a dual registration as they are also registered to manage one of the providers other homes. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, this included

notifications made by the service and concerns raised with the Care Quality Commission. We used all of this information to plan our inspection.

We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 and made the judgements in this report.

During the inspection
We met people who lived at the home and spoke with twelve of them about their experience of the care provided. We also spoke with three relatives visiting the home to ask them about their views of the service. We spoke to nine relatives by telephone to ask them their views.

We spoke with fourteen members of staff including the registered manager, the provider's operations manager, both unit leads, the administrator, the maintenance person, team leaders and care workers. We also spoke with a healthcare professional visiting the service to ask about their views.

As most people were living with dementia, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people and staff in the Pinnexmoor lounge and dining areas during breakfast, morning, lunch and afternoon. We also observed people and staff in the Ashdowne unit during lunch.

We reviewed a range of records. This included four people's care records and medication records. We looked at a variety of records relating to the management of the service, including tissue viability records and two recruitment folders.

After the inspection
At the inspection we asked the registered manager to display our poster asking staff and relatives to share their views. We also asked they share the poster with relatives via email. We received seven responses from relatives of people at the service and four staff responses as a result of the posters.

We also contacted seventeen staff to ask for their views about the service and received a response from four of them.

We spoke with the provider to discuss the inspection findings and hear about their plans for the future.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

●Improvements continued to ensure there were enough staff on duty at all times. The registered manager had a full care staff team and had a nurse and a housekeeping vacancy. The rota showed that they allocated the assessed staffing level. Since our last inspection after feedback from staff this had increased on the Ashdowne unit to six staff throughout the day.

●However there had continued to be a problem with high levels of staff sickness, some of this was due to Covid-19 and staff having to isolate. The registered manager or the unit lead followed up all staff sickness to support the staff back to work. The registered manager said the sickness levels had reduced slightly. Staff said sickness levels were improving but was still having an impact.

●People gave us a mixed view about the staffing levels at the service. Comments included, "The call bell being answered depends who is working. Sometimes it is quite good other times it is a very long wait"

●Staff had concerns about having a consistent staffing level at the home. Comments included, "We have difficulty in covering when staff call in sick at short notice" and "Sickness absence was a problem but now as there are more staff then seem more reliable."

●Relatives mostly gave positive feedback about the staffing at the home. Comments included, "Overall the service and personal care is very good, but limited as the carers are overworked", "There seems to be plenty of staff to look after her and she is happy and healthy enough" and "When I have visited my experience is that there have been enough staff around to look after everyone."

●The registered manager said their biggest issue was staff turnover, which was something they were looking at. They said if they recruited six new staff, they would be lucky to have two left by the end of three months. This had an impact on staff who supported new staff through induction. Recent leavers included those going to university as well as people who had been on furlough from other industries. The provider had worked with an agency to recruit six staff from India on sponsorship visas to help with staffing at the home.

● Staff had been safely recruited. Staff had pre-employment checks to check their suitability before they started working with people. For example, criminal record checks and references from previous employers.

Systems and processes to safeguard people from the risk of abuse

● Staff demonstrated an understanding and awareness of the different types of abuse. They knew, how to respond appropriately where abuse was suspected and how to escalate concerns to the management team and external agencies, such as the Local Authority and Care Quality Commission (CQC).

●Staff had received safeguarding training.

●The registered manager was working with the local authority safeguarding team regarding some recent safeguarding concerns. As a response to these concerns the registered manager had implemented measures to ensure people were safe.

Assessing risk, safety monitoring and management

● People told us they felt safe and relatives confirmed they had no concerns relating to the safety of their family member. One person said, "I do feel safe here, they look after me very well, but there are little things that drop it from being excellent." Relatives comments included, "The home provides care that keeps the residents safe" and "My Mum is safe in the home. Security is very good, and they have followed all the regulations regarding covid-19."

● Fire safety was well managed. Regular fire checks were carried out and people had an individual risk assessment for evacuation in the event of a fire, which was regularly reviewed. On the day of the inspection the weekly fire alarm was activated. This identified one door which did not close. Immediate action was taken to resolve the issue. This ensured people would be safe in the event of a fire.

●We discussed with the registered manager that we had found some toiletries left in communal bathrooms. This could pose a risk to people who may not have an understanding of what the chemicals were and use them unsafely. They said they would remind staff to return people's toiletries to their rooms.

● Staff had completed risk assessments for people in relation to individual risk assessments for falls, nutrition monitoring and skin integrity. People identified as at an increased risk of malnutrition had fortified drinks and were regularly monitored and people with skin damage had pressure relieving equipment in place to protect them from developing sores.

Using medicines safely

●Medicines were safely managed. A relative said, "The home administers his medication, there has never been any issues and they keep a member of the family informed if the medication has to change."

●All staff that were administering medicines had received training around the safe use of medicines and had their competency had been assessed.

●The pharmacy that provides medicines to the service had undertaken a visit at the home on 7 July 2021. They had not raised any significant concerns. Where they had identified improvements, these were being actioned. For example, monitoring the temperature of the medicine trolley, additional training and that liquids have an opening date, such as eye drops and creams.

●There had been an improvement regarding timings of people's medicines. Previously the registered nurses undertook medicine administration which took a long time due to the quantity of medicines they needed to dispense. The registered manager had trained team leaders to be able to administer medicines, so they shared the medicine round making it shorter.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance. Although some people and relatives were not always clear about the government's guidance and the visiting arrangements at the home.

Learning lessons when things go wrong

- The registered manager and operations manager were constantly looking to make improvements where needed. For example, they had a checklist for staff when a unit lead was off. After a recent unit lead absence, they had identified some gaps and were looking to add tasks.
- Staff were extremely good a recording all accidents and any injuries or bruising they identified.

We discussed with the management having an oversight of people's bruising, to assure themselves how bruises had happened and was there any learning needed. A bruise grid and analysis were put into place and completed during the inspection.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Pre-assessments were carried out, to ensure people's needs could be met before moving into the home. The assessment considered people's needs and choices and the support they required from staff, as well as any equipment which might be needed.

●Relatives said they were kept well informed and were involved in decision making. Comments included, "The home calls us when he has a fall and tells us what has happened" and "I have been included in making decisions regarding her care in care plan meetings. The home is very good at keeping me updated about her condition..."

●The registered manager had introduced electronic care records. This was being used on the Ashdowne unit, but not on the Pinnexmoor unit. This had caused some minor issues when people transferred across the units. The operations manager and provider said they were going to implement a new electronic care planning system across the whole home but were working to get their internet access improved.

Staff support: induction, training, skills and experience

● Staff had the skills and knowledge to deliver care effectively. The provider had improved training and systems for monitoring training to ensure staff were appropriately trained to meet people's needs. The provider used two online training provider's and some face to face training with in-house trainers. There was a clear oversight of staff training and when training needed to be renewed this was happening in a timely way.

●Staff said they had received training to support them to work with people, although they said this had been limited to online training since Covid-19. Staff said they had received training in fire, moving and handling as well as training to support their skills and knowledge e.g. oral hygiene and dementia care.

●People and relatives said they felt staff had the skills needed to support them safely. Comments included, "They provide excellent care and have no complaints at all", "The staff really look after Mum well. They totally understand her dementia needs, they are well trained" and "The staff are well trained and look after him very well. They deal with all his personal and health issues."

●Staff were expected to have at least two supervisions a year and an annual appraisal on the anniversary of them joining the service. There was a cascade system with the registered manager doing lead nurses, then lead nurses doing team leaders and team leaders doing care staff.

●Staff said on the whole said they felt supported but not always valued. Comments included, "Many staff do not feel valued and there is constant pressure to cover shifts on days off." The registered manager had set up a 'WhatsApp' group to help improve communication and staff involvement.

● Staff new to the service completed a period of induction and the providers induction pack. They had opportunities to work alongside more experienced staff to get to know people and learn about their

preferences and care needs.

Supporting people to eat and drink enough to maintain a balanced diet

●People and relatives mostly told us the food at the home was good and they were offered choices. Comments included, "They come round to ask about choice for meals about 3.00pm but I am often sleeping then, though you can choose the following day", "Mum tells me the food is very good, she doesn't appear to have lost weight. She gets drinks and snacks through the day too", "My relative gets good food. I've eaten at the home myself and I enjoyed the food. She gets tea, coffee, biscuits and cake too" and "Mum has put on weight in the home, so she is eating the food. She gets cups of tea and they have been building her up, so she gets fortified drinks."

● Staff said night staff helped people who were early risers to get up and were able to get them a drink (and toast if wanted) but breakfast was not served until 8.45.

● Improvements were needed to make sure the mealtime experience was a pleasant social occasion for all people at the home. On the first day of the inspection we observed lunch on the Pinnexmoor unit. Three staff members did not show care and attention when supporting people with their meals. This included for part of the meal a staff member standing over a person and not ensuring a person was sat up correctly. They did not wait enough time between mouthfuls and offered large spoonsful. When a person spilled food on their chin not wiping the food off and not interacting with a person when supporting them.

●We fed this back to the unit lead who had also witnessed the mealtime and said they had already addressed the concerns with staff and were looking at ways to help staff improve their practice around mealtimes.

●Care records included monitoring for weight and malnutrition screening tool (MUST) to identify those at risk of weight loss. Where people were identified as losing weight or having difficulty swallowing, staff had contacted people's GPs and Speech and Language Therapy (SALT).

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People's physical and mental healthcare needs were being well-monitored to recognise any signs of deteriorating health so action could be taken. Relatives told us they were contacted promptly if there were any concerns. Comments included, "The carers seem quite knowledgeable and will notice if (relative) has an issue. They have called the family when needed and given verbal feedback to us."

● The GP contacted the home weekly to discuss people's health concerns.

● The advice given by healthcare services was included in people's care plans and followed by staff. One healthcare professional told us, "They are always open to learning from the team…all things suggested have been implemented."

●Staff received a handover when they arrived on shift to ensure information about people's changing needs was shared.

●Staff used walkie talkies at the home. This was so staff could find staff and request assistance. Staff were aware of data protection and did not share people's information on the walkie talkies.

Adapting service, design, decoration to meet people's

● Since the last inspection an additional large lounge area had been added to the Pinnexmoor unit, two new bedrooms and toilet facilities. The lounge was large and spacious and had a bar area which had not been set up at the time of our visit.

●The registered manager was developing a more dementia friendly service including memory boxes outside people's rooms but only some of these were filled. Some rooms had been personalised while others were not. There were some picture/symbol signage to help people to locate bathroom and toilet areas independently.

●Some areas of the home had been upgraded and decorated. However other parts of the home felt tired and in need of some refurbishment, for example wallpaper had been ripped. The operations manager told us they had a programme of refurbishment to redecorate and replace flooring.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

●Care plans reflected the principles of the MCA and DoLS and appropriate applications to the local authority had been made where restrictions were in place.
●Staff had received training on the MCA and demonstrated a good understanding of the MCA and how this impacted on people they worked with.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager had a dual registration with CQC and managed two homes for the provider. They were supported by the operations manager, two-unit leads, nurses and team leaders. Staff were positive about the registered manager and said they had made improvements. One commented, "The home is definitely moving in the right direction, but a lot of the daily issues seem to be caused by staff sickness." However, some staff raised concerns about the registered manager's communication and not being at the service regularly. Comments included, "The manager is a hardworking man, but he is spread quite thinly between here and (second home they managed). He is a good manager but doesn't communicate very well and this often causes upset."
- The registered manager was very responsive to this feedback and said they would work to improve their communication. The operations manager said the registered manager was at Ashdowne more than the second service and was always available. This was evidenced during the inspection as the registered manager was on leave and attended the inspection. The provider told us they were looking at additional management support for the registered manager to help their role.
- The two-unit leads were passionate about their units and we received positive feedback from health care professionals about both unit leads. One visiting health care professional said, "Always found (unit lead) provided a culture of good practice…all things suggested have been implemented. Find it difficult to get key information about some if (unit lead) is not here." A relative said, "The management are also very friendly and helpful".
- Staff gave us mixed feedback about one of the managements leadership style. We observed that staff were not always empowered in their roles and trusted to undertake tasks without supervision. We discussed this with the operations manager and registered manager who had already identified this and was working to make improvements.
- Prior to our last inspection the registered manager had introduced the role of team leaders. The new team leaders were still developing their knowledge and skills to ensure they were able to operate effectively. The operations manager said they were impressed with team leaders and their confidence in communication with professionals, which we also observed.
- People and relatives said they would be happy to raise any concerns to the management team at the service. Comments included, "The manger has changed a lot in the last few years which can be a bit

unsettling, but I would be happy to raise a concern…though I have not needed too. They do seem to care, and I think it would be looked into and sorted."

● Regular checks of the environment and servicing and maintenance of equipment was carried out to identify and minimise environmental risks.

● The operations manager worked closely with the registered manager. They undertook monthly quality monitoring audits and actioned any concerns.

● Monthly monitoring of accidents/incidents were used to identify any themes or trends needing further action to reduce risk.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager was working closely with the unit leads and other senior staff to promote person centred cared, which was focused on people's individual needs.

● Staff had daily handover meetings, where each person's care was discussed, so they were aware of people's changing needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●Where mistakes were made, the registered manager was open and honest with people and families and worked to make improvements.

● The registered manager notified Care Quality Commission (CQC) of events which had occurred in line with their legal responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were consulted and involved in day to day decisions about the running of the home.

● Staff were consulted and involved in decision making with regular meetings, staff handover and individual supervision.

Continuous learning and improving care; Working in partnership with others

● Staff were encouraged to develop further qualifications and skills relevant to their work. Staff were enrolling on higher health and social care qualification courses to increase their knowledge.

● People lived in a home where staff worked in partnership with health, social care professionals and family members to make sure people received the care and support they needed. For example, local GP's, community nurses, physiotherapists, chiropodists and social workers.