Julian Support Limited

Ashcroft

Inspection report

Milestone House
Wicklewood
Wymondham
Norfolk
NR18 9QL

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13 July 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 July 2016 and was unannounced.

Ashcroft provides accommodation and care for up to 14 women who need support with mental health. It is also staffed by women. It offers a service for people discharged from hospital who are not yet well enough to return home. It also offers respite care, which can include people who would otherwise need admission to hospital. There are sometimes people receiving support on a longer-term basis. At the time of our inspection, there were six people using the service.

There was a manager in post who completed registration with the Care Quality Commission (CQC) in August 2015. A registered manager is a person who has registered with CQC 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 experienced a service that was safe. The manager acknowledged the need to review arrangements for storing temperature sensitive medicines if people using the service needed any of these. They also assured us they would look at how some medicines were recorded and audited to minimise the risk of errors. However, people's medicines were administered in a safe way and given to people as the prescriber intended. People received support from enough staff, who were properly recruited, which contributed to promoting people's safety. Staff understood the importance of reporting concerns when people may be at risk of harm or abuse and of supporting people to understand risks to their wellbeing.

People received a service that was effective. Staff were well supported and trained to meet people's needs. They undertook additional research to boost their knowledge and skills if they needed to and shared this with colleagues. Staff understood the importance of assisting people to make informed decisions about their care and seeking people's consent and agreement to the support they offered to people. Where people needed to seek advice about their health or wellbeing, staff supported them if required. They also encouraged people to make choices about what they ate and drank.

People received support from staff who were kind and acted with respect for people's privacy and dignity. People were involved in planning their care and making decisions about priorities they wished staff to support them with. Staff incorporated people's wishes, interests and preferences into the way they offered support to people so that this focused on the needs of each individual. There was a core of long standing, established and skilled staff who had come to know many of the people who used the service well but did not make assumptions that people's support needs were the same each time they used the service.

People were confident that any concerns or complaints they had would be listened to and addressed. The management team regularly asked people for their opinions about the quality of the service and support they received.

Staff were highly motivated and enthusiastic about their work. They understood the standard of care that they were expected to deliver. The management team had developed a culture within which staff and people using the service felt free to seek support if it was needed, to ask for advice and to make suggestions for change or improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines in a safe way and as the prescriber intended with minor concerns about storage and recording.

Recruitment processes were robust and staff understood the importance of protecting people from abuse. There were enough staff to attend to people's care needs safely.

Risks to people's safety were assessed and minimised where practicable, taking into account people's rights to take risks as part of their daily lives.

Is the service effective?

Good

The service was effective.

Staff were well trained and competent to support people effectively. They understood the importance of seeking people's consent and agreement to their care and respected people's rights and freedoms to make decisions.

Staff supported people to access advice about their health and welfare if it was needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and cared about people's wellbeing.

Staff treated people in a way that respected their privacy and dignity and encouraged their independence.

Is the service responsive?

Good

The service was responsive.

Staff were flexible in responding to people's needs and

understood their preferences so that people received support that was focused on their individual needs.

People were confident that their concerns or complaints would be listened to and addressed.

Is the service well-led?

Good

The service was well-led.

People and staff were encouraged to express their views about the quality and safety of the service.

Leadership within the service was inclusive and open to ideas about improvements that needed to be made.

Ashcroft

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.

The inspection took place on 13 July 2016 and was unannounced. It was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or manager must tell us about by law.

During our inspection, we spoke with two people who used the service. We gathered further information about people's experiences from questionnaires they had completed. We interviewed the registered manager, deputy manager and a member of the care team and spoke briefly with a further member of staff.

We reviewed records relating to the care of three people, medicines administration records and other records associated with the quality and safety of the service. We observed staff interactions with people using the service and with each other.

Good

Is the service safe?

Our findings

People received their medicines as the prescriber intended. Staff knew how to administer medicines safely and their competence was assessed. However, there was a potential risk that temperature sensitive medicines could not be stored properly if they were needed; there were some inconsistencies in record keeping practices and audits.

There were daily checks on the temperature of the drugs fridge, which would be used to store any medicines that needed to be kept cool. The recording sheet stated that staff needed to report promptly if the fridge operated outside of the expected range. This had not happened despite it consistently running below the minimum specified temperature. A staff member said they thought one reading of below freezing point might have been mistake. This risk did not affect people using the service at the time of this inspection, because they did not need medicines stored in this way. However, there was a potential risk for safely storing medicines such as insulin, should anyone be admitted to the service who needed their medicines to be refrigerated, as had happened in the past.

We found concerns about the consistency of one administration record used to record medicines prescribed for occasional use (PRN). The management team had introduced an additional recording chart for PRN medicines because of a recommendation arising from a local pharmacy audit. Staff made entries on both the main medication administration record (MAR) chart and on a separate PRN record. For one person, there were anomalies between these two records where staff had completed one record and not the other. However, we were able to account for all of the tablets.

We reviewed a sample of other records and balances of medicines remaining in stock and found that these were accurate and complete. There was clear guidance about the use of medicines prescribed for occasional use, for example if people became anxious or distressed.

People were able to manage their own medicines if they wished and subject to an assessment of how they would do this safely. At the time of this inspection, two people wished to manage their own medicines as a part of their recovery process. They had signed individual agreements about storing medicines, seeking staff support if they needed it and the checks staff would make to ensure their safety.

The service was operating in a way that contributed to protecting people from avoidable harm and abuse. People felt protected from the risk of abuse while they were staying at Ashcroft. One person told us, "I feel safe here. I have no concerns about the way I've been treated." Each person completed a questionnaire about their experience when they left the service, for example after a stay for respite support. These too showed positive comments regarding people's views about the safety of the service. For example, one person had written, "I feel safe."

Staff spoken with confirmed that they had training to recognise and respond to suspicions that someone may be at risk of harm or abuse. They were clear about their obligations to raise any concerns. Leaflets explaining how people should be free from abuse were available to both staff and people using the service,

in the main entrance hall. These contained details about how people or staff could contact the local authority to raise any concerns or suspicions.

People's plans of care contained detailed assessments of risks to which they may be exposed. There was guidance about what staff needed to do to support people in managing and minimising these. Assessments covered a variety of areas including those associated with people's physical and mental wellbeing. Risks of abuse and exploitation, social isolation or self-harm were also addressed. Where possible, records showed early warning signs of escalating risks so that staff were aware of the need to monitor and intervene. Those seen also took into account people's rights to take risks, and recognised risk taking as a part of recovery for some people. Staff spoken with recognised the need to balance risks, including those associated with self-harm, with people's freedoms.

During our inspection, we observed discussions between the management team and a staff member about potential risks for someone not yet using the service. These discussions reflected specific risks, and whether the service could support the person safely. The management team also gave us an example of considering specific behaviour associated with risk taking. They had concluded that the placement was not appropriate because there was a risk that the rights of other people using the service would be compromised.

Risks within the environment were assessed, with guidance about how these could be minimised. We noted that staff were trained what to do in an emergency such as a fire. The training included the use of fire extinguishers so that they could tackle a minor outbreak if it was safe to do so. There was a register of people living in, visiting and working at the home by the main entrance. This was together with a plan of the service and relevant information for the fire brigade if it was needed in an emergency.

There were enough staff on duty to support people safely. A person spoken with told us that staff were always available to them. They said that, even though there were sleep-in staff rather than staff who were awake during the night, staff were always willing to help if people needed assistance. They told us, "There's always someone to talk to 24/7." This was confirmed in the findings of surveys we reviewed. For example, one person commented, "I feel well supported here. There are always staff to talk to."

Staff commented that, although they were busy, they did not feel that staffing levels were unsafe. They expressed confidence that the management team assessed people's needs appropriately so that risks to individuals, and the ability of the staff team to manage these safely, were considered.

Recruitment processes contributed to promoting people's safety. Although there were no new staff on duty with whom we could discuss this, the registered manager outlined a clear recruitment process to us. They told us about the checks that they made on the suitability of applicants. This included taking up references and completing enhanced checks to ensure prospective staff were not barred from working in care. The provider's human resources department oversaw the process and provided us with confirmation after our inspection visit, showing the required checks were completed.

Application forms asked people to supply their employment histories and reasons for leaving previous posts. The registered manager was aware of the importance of checking for gaps in work histories and seeking clarification about these. The registered manager showed us how they planned forthcoming interviews, so that they asked applicants the same questions as each other to help promote fairness in recruitment practices. We noted information from one of the provider's procedures, that they expected staff to cooperate with renewing enhanced background checks to ensure they remained suitable for their role. This represented good practice in contributing to protecting people.

Good

Is the service effective?

Our findings

Staff spoken with confirmed that they had access to training to enable them to meet the specific needs of people they supported. One commented that the training was better than it used to be and more tailored to the service. They also explained how staff researched unfamiliar areas using the internet, seeking out information they could share about particular issues. We saw some of this information on file for staff to refer to.

There was a core of long standing staff in the service. The service largely supported people with short stays and respite and so there were frequent changes in the people who lived there. However, the consistency of some key staff meant that they had built up a good knowledge of people who returned to Ashcroft periodically. Discussions between the staff team confirmed this.

The registered manager monitored staff training through supervision, appraisal and on line records to ensure that gaps, or training that was coming up for renewal, were addressed promptly. Staff told us that they received supervision and support. One said that they regularly received support and feedback about their work.

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 so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether there were any concerns that people may be being deprived of their liberty.

One person told us how staff always involved them in decisions about their care. The questionnaires we reviewed and that people completed after their stays, all reflected that they were encouraged to make decisions about their care. Our discussions with staff showed that they were aware of the importance of involving this. They recognised that sometimes people would need time, explanation or support to make informed decisions if they were experiencing poor mental health.

However, the service focused on engaging people in a way that assisted them with their recovery. People needed to understand and agree to the contracts they made with the service and their consent was recorded within plans of care. While staff explained risks to people, they understood the importance of people making their own decisions. People were free to enter and leave the home and so were not deprived of their liberty.

People had enough to eat and drink to meet their needs. People were able to have something to drink when they wanted to. One person told us, "We can make tea and coffee whenever we like." Staff explained how they supported and encouraged people to prepare their main meals but did not cook for people directly. During our inspection, we saw that a staff member assisted one person to do the shopping they needed in order to prepare their meal.

We spoke with a member of the management team about risks associated with people not eating or drinking enough. They explained that they did not generally assess this formally as part of care packages as most people did not spend a long time in the service. The involvement of the staff team was primarily with prompting and encouragement. They said this was where people's history indicated they might be at risk of self-neglect and so might not be eating or drinking properly. They gave us an example of reviewing the suitability of one person's placement, due to serious concerns about their fluid intake arising from poor mental health.

The information the provider sent to us before our inspection, showed that the service sought advice from the local GP if people became unwell during their stay. Records we reviewed showed that this happened. Support arranged with people and on their behalf by staff, was primarily to maintain or improve people's mental health. We could see that there was input from people's mental health workers and the crisis team where appropriate. A counsellor attended the service regularly and people could make appointments for discussions with them if they wished.

Good

Is the service caring?

Our findings

Staff had developed positive, caring relationships with people. During the course of our inspection, we heard chatter, laughter and banter between people using the service and the staff on duty. People described the staff as caring. One person told us staff always asked how they were feeling. There were comments in people's questionnaires showing how they valued the approach of staff. For example, one person said, "They helped me to build confidence and self-esteem." Another wrote that staff, "…went above and beyond the call of duty every day." Others commented, "I have received fantastic support," and, "The staff have been brilliant."

The provider's information return (PIR), sent to us before our inspection, told us that people were involved in developing their support plans and goals for recovery. They also said people were also involved in recruiting staff. Our findings confirmed what the PIR said.

People were involved in decisions about their care and were supported and encouraged to express their views. We saw that people were able to visit the service before they decided whether to use it or not. This happened during our inspection. Staff showed a person around the home and explained how the service worked to support people.. A person who had used the service told us, "They give you loads of leaflets about things." They said this meant they knew what to expect about the service and whom they could contact.

People were encouraged to assess their own level of anxiety when they first arrived at the service. Staff then used this with people to identify aspects of their wellbeing they wanted to address and prioritise during their stay. We saw that people's plans of care recorded these goals, with agreements about how people and staff would work together to address them. Staff knew about people's histories and how these might affect their welfare. They told us that, as only women used and staffed the service, people felt secure in seeking support.

One person told us how staff encouraged people to express their views. They explained that staff had fixed a whiteboard up for people to write down how they felt if they wanted to. They cleared it at night ready for a fresh start the next day. They explained there was also a 'tree', which people could leave messages on. This was about things that may have helped or inspired people and could possibly help others.

We noted that staff checked who people wanted to be involved in discussions about their care each time they used the service, if they were receiving regular respite care. This meant that they did not make assumptions that the person's wishes would be the same as when they last used the service.

The manager told us how people were involved in recruiting staff to the home. They had their own questions to ask, to assess how prospective staff performed. These particularly considered how warm and empathetic applicants were during the interview process.

Staff respected people's privacy and dignity. People were offered keys to their rooms when they arrived for their stay. We observed that staff respected people's privacy but were alert for any developing risks. We

noted that one person went to their room but staff checked with one another how they felt the person was. After discussion, they also checked with the person themselves to ensure they were okay. Care records showed what might indicate concerns for people's wellbeing and when 'welfare checks' should be made.

During our inspection, the registered manager discussed a prospective placement with members of the staff team. These discussions took account of the potential adverse impact on others who used the service, their rights and welfare. We also observed discussions between staff, which showed how they were sensitive to people's dignity. They spoke in respectful terms about how they would approach the person about a particular issue in a way that respected their dignity and independence.

People were able to have confidential discussions with staff, other professionals or their visitors. They could use one of two quiet lounges, if they did not wish to receive people in their rooms or in main communal areas. People's personal information was held securely in the staff office. Where computer records were maintained, staff needed secure 'log-in' details to prevent unauthorised access to people's information. Discussions between staff took place in private, so contributing towards protecting people's confidential information.

Good

Is the service responsive?

Our findings

People felt that the service they received from staff was flexible, based on their needs and considered changes from day to day. One person explained how they, "…had one bad day. They talked me through it and really helped." They went on to tell us, "They involve you in things and always talk to you about your care plan." We found comments in their surveys showing how staff responded to people's needs. For example, one person commented, "They [staff] always find time to give one to ones and always offer encouragement and support."

The support that staff offered to people was focused on, and responsive to, their individual needs and took into account their preferences. Despite frequent changes in who was using the service, staff were knowledgeable in discussions with one another and with us, about people's preferences and needs. For example, they were able to comment clearly about regular and recurring admissions for respite care. They understood what triggers and signs there may be that an individual's mental health was deteriorating and how they should support them.

We noted from records that staff re-assessed people's needs and risks with them when they returned for repeat visits, to ensure they always had up to date information about any changes. When someone used the service for a longer period, staff implemented a regular programme of review with the person. This took into account the person's progress and whether they wanted any changes made to the way they were supported. Care records also reflected who else people wanted to be involved in assisting them to plan their care. If they had identified anyone they wanted to be involved, they recorded their agreement for contact with the person in their records. There were monthly reports compiled after visits by an independent person to assess the service people received. These also showed that people were involved in planning their care.

We noted that staff were flexible in response to changes in people's anxiety levels. For example, we saw one report indicating that a person had requested a medicine prescribed to assist them for use when they became anxious. We could see that staff discussed with them alternative ways of coping with their anxiety levels. The person had very quickly agreed that they did not need the medicine and felt better having received the support and advice.

We reviewed the comments people made about their stays and their self-assessments about the way they were feeling. Almost all of these indicated that people felt they had made progress in dealing with their anxieties and working towards their goals. Where one person had not, staff explored with them why this was. This was for personal reasons rather than because they had not been able to work towards their goals while they were staying at Ashcroft.

Our discussions with staff indicated that they tried to equip people with coping strategies they would need when they returned home. In one example they gave us, this included assisting someone with supermarket shopping where they were using Ashcroft after a time in hospital. They were anxious about doing this for the first time in about three months. Staff arranged to support them with their first shopping trip to build their confidence.

People's interests and any hobbies they may have were taken into account. We noted that, at residents meetings, people agreed a planned rota for spending time on their own with staff. One person told us, "They offer me things sometimes and it's up to me about whether I join in or not."

Although the service no longer employed dedicated therapists, for example for art therapy, staff tried to support people with the things they wanted to do. Notes from residents' meetings showed that staff took into account what people said they would like to do. For example, some people enjoyed walking and a small group was set up to do this. Staff supported people to use the art room if they wanted to. There was also a baking group, which took place during our inspection, and a Saturday evening 'pamper' session. This gave people the opportunity to relax with a foot-spa, facial massage and manicure if they wished.

One person told us how they did not have any complaints but were confident staff would listen to them if they had. They said that staff gave them information about how to complain when they came to stay at the home. The registered manager told us in the provider information return that they reviewed the comments people made in their questionnaires when they left the service. We found that one person had expressed some concern and the registered manager was able to explain how they addressed this. They confirmed that they had spoken to the person and their family member to explore the issues. They had also emphasised the person's right to make a formal complaint if they did not feel their concerns were addressed. The person was satisfied they did not need to do so.

Good

Is the service well-led?

Our findings

We found records indicating there were weekly medicines audits but none were completed since 9 May 2016. The nature of the service meant that there were frequent changes in the amounts and types of medicines held. We discussed with the registered manager, that this made it even more important that staff should understand what they were expected to check and report on in their daily hand overs or in medicines audits. The registered manager undertook to review arrangements promptly.

We found that there were regular checks on health and safety within the service. This included safety in the event of fire. Monitoring of health and safety highlighted whether there was any learning and improvements that could be made following incidents. This was in addition to quality audits across the organisation, for example of care plans and risk assessments. The registered manager explained how findings from internal audits were fed back to the provider's management team. They agreed that staff might need additional guidance about the checks they made on medicines management on a daily basis. This would help to ensure that they could address issues more promptly.

People using and working in the service were encouraged to express their views and the management team considered these in the way the service was operating. People had opportunities to express their views at regular meetings. One person told us, "We always have a say in how things are going. There are meetings every week. They [staff] jot things down and they tell you what they are doing."

In addition to these meetings, each person completed a questionnaire asking for their views about the quality and safety of the service they had received, when they were leaving the service. We noted that one of these commented the person would recommend Ashcroft to others in their circumstances because it had helped them so much. All of the questionnaires we reviewed rated the service people received as excellent.

The independent visitor, completing monthly checks at the service, ensured they took into account the views of people using the service and of staff. The reports we reviewed reflected people's confidence in the way the service was running and that staff morale was improving after a period when the immediate future of the service had been in doubt. Our observations and discussions with staff indicated this was the case and that staff were motivated and committed to delivering good support. Two staff members confirmed how much they enjoyed their work.

The manager completed registration with the Care Quality Commission (CQC) in August 2015. The deputy manager was appointed soon afterwards so the new management team had been in post for approximately a year. Our discussions with them showed that they were sensitive to the impact the change might have on staff when they were first appointed. They expressed confidence in the staff team's skills and abilities and said they had taken time to build up relationships with staff.

A staff member told us how this had happened, that they felt the approach of the management team was consultative and listened to their views. They described the leadership of the service as very open. The management team told us how they had tried to increase staff skills and knowledge about all the day-to-day

processes in the home, including admissions and assessment processes. A staff member confirmed this and said that they had never felt as well supported, they were more confident about dealing with things and answering questions. They said that they received constructive feedback about their work when this was needed.

The registered manager participated in the provider's central management team meetings and leadership forum to remain up to date about developments or changes. The registered manager explained how they used staff meetings to consider suggestions for improvement and to keep staff up to date. The provider also operated a 'suggestion scheme' for staff.

The registered manager understood what they needed to tell CQC about, when particular events took place within the service. We emphasised the importance of ensuring they took appropriate action in relation to the registration as they had decided to reduce the numbers of people using it by one. The provider undertook to deal with this promptly following our visit.