

Making Space

Ashwood Court - Unit 1

Inspection report

Woodford Avenue
Lowton
Warrington
Cheshire
WA3 2RB

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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

Ashwood Court-Unit 1 is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The inspection was unannounced and completed on 25 October 2018.

The purpose-built home is situated in Lowton, Greater Manchester and benefits from all ground floor accommodation. The home is registered to provide care and support to 17 adults living with a mental health diagnosis. There were 16 people living at the home at the time of the inspection because one person was in hospital. People varied in age from 35 to 110.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

During the last inspection, although the home was rated as good overall, it was rated as requires improvement in the key line of enquiry (KLOE) effective because we made a recommendation. This was in relation to the application of Deprivation of Liberty Safeguards (DoLS).

At this inspection we found the provider had addressed our recommendation. Staff had received training in MCA and DoLS and when people were identified as not having capacity to consent to their care and treatment, applications to request a DoLS had been made to the local authority.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Everybody spoken with told us they felt safe living at the home. Appropriate recruitment checks had been completed prior to new staff working at the home and the safeguarding processes were organised and transparent.

There were sufficient numbers of staff on duty to meet people's needs. Rota's were flexible and staffing numbers increased when required to facilitate appointments and day trips.

People had comprehensive risk assessments and 'my plans' completed by staff which contained control measures to reduce risk. These were easy to navigate and contained all the required information to meet people's needs safely.

We found medicines had been managed safely. There were effective systems in place to ensure medicines were ordered, stored, received and administered appropriately.

New staff received an induction which was aligned with the care certificate and all staff completed regular online training through e-learning for you (elfy). Staff had quarterly supervision and an annual appraisal of their work.

Staff demonstrated they were knowledgeable regarding the Mental Capacity Act (MCA 2005) and DoLS. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us staff were caring and friendly and respected their privacy and dignity. They confirmed being given choices about their care and personal preferences were considered.

The home was meeting the accessible information standard. People had a communication plan at the start of their care file and there was an accessible information resource file in the foyer of the home to support staff.

People accessed the community independently and there were afternoon activities and organised trips people participated in.

The complaints process and outcomes of surveys was clear and transparent. People and visitors were updated on the compliments, survey responses and complaints received.

Audits were completed which were aligned with CQC's KLOE's and identified whether the standards were met and actions taken if not.

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 remains Good.

Is the service effective?

Good ●

The service has improved to Good.

Staff demonstrated they understood the requirements of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS).

Staff received appropriate training, regular supervision and had an annual appraisal of their work.

Referrals were made to other health professionals to ensure people's individual medical needs were being met.

Is the service caring?

Good ●

The service remains Good.

Is the service responsive?

Good ●

The service remains Good.

Is the service well-led?

Good ●

The service remains Good.

Ashwood Court - Unit 1

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 was unannounced and conducted on 25 October 2018 by one adult social care inspector from CQC.

Before this inspection, we reviewed notifications we had received from and about the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, and tells us what the service does well and the improvements they plan to make. We also checked with the local safeguarding and commissioning team whether they had any concerns about the service. All this information was used to plan the inspection.

During the inspection we spoke with three people who lived at Ashwood Court-Unit 1. We also spoke with the registered manager, administrator, senior carer and two care staff.

We looked at two care files, four medicine administration records (MAR), activities and observed care being provided in communal areas. Other records viewed included; two recruitment files, four staff files containing probation, supervision and appraisal records, training, induction processes, staff rotas, minutes of meetings, compliments, complaints, surveys, audits and policies and procedures. We used this information to inform our inspection judgement.

Is the service safe?

Our findings

People spoken with told us they felt safe living at the home. People said; "It's a quiet home. Very settled. I feel safe living here" and "You don't need to have concerns about here. We are all safe and well cared for."

Staff continued to be recruited safely because all required pre-employment checks had been completed prior to new staff starting to work at the home.

There were sufficient numbers of staff on duty to meet people's needs. We looked at four weeks rota's and found many occasions where there were more staff on duty than the minimum numbers required. Staff and the registered manager confirmed staffing was flexible depending on people's needs and staffing numbers frequently increased to accommodate appointments and trips out.

Medicines were managed safely and there were structured and organised processes in place at the home. We looked at four medicine administration records (MAR's), staff had completed these consistently and all medicine stock balances tallied which confirmed medicines had been administered as prescribed.

Each person had an information sheet alongside their MAR, which contained their name, date of birth, photograph, allergy information and how they liked to take their medicines. We saw 'as required' (PRN) protocols in place for people who took this type of medicine, for example paracetamol. These provided staff with information about what the medicine was for, when and how to administer. This ensured staff administered medicines to the correct people, when necessary and in the way the person wanted.

The safeguarding processes were organised and transparent and all staff had completed in house safeguarding training. The safeguarding procedures were aligned with the local authority's tier system for reporting and staff, except for three, had received local authority training. People had personalised and up to date risk assessments which detailed the severity of the risk and signs and behaviours the person presented with so staff were aware when risks had changed. 'My plans' detailed how people wanted their care and support to be delivered and outlined measures and strategies to implement to manage and reduce risks presented.

We looked at accident and incident information and found these had been documented as necessary. Reviews of accidents had been completed and included action taken to prevent future risks.

There were general environmental risk assessments in place and people had personal emergency evacuation plans (PEEP's) to support evacuation of the home in the event of an emergency. The plan contained general details of how the person spent their day and how they were likely to respond in the event of an emergency. People completed fire safety awareness training which informed them of the day the fire alarm was tested and clarified whether they knew where their nearest fire exit was in relation to their bedroom and communal rooms.

People had been protected from the risk of infection by staff who had received training and had access to

appropriate equipment, including, gloves, aprons and hand gel. The home had received 96% on the recent infection control audit.

The premises and equipment continued to be maintained and serviced within required timeframes including, gas, electricity and lifting equipment such as hoists.

Is the service effective?

Our findings

We checked the progress the provider had made following our last inspection in January 2016 when we made a recommendation in relation to the application of Deprivation of Liberty Safeguards (DoLS).

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we found the provider had made the required improvements and addressed our previous recommendation. Staff demonstrated a good understanding of the MCA and supported people to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible and we observed people had access to door codes and came and went from the home freely throughout the inspection.

When a person was deemed not to have capacity to consent to their care and treatment, mental capacity assessments were completed to evidence this. We found DoLS applications had been submitted for anybody deemed to lack capacity to consent to their care and treatment and/or where a restriction had been identified. The registered manager tracked referrals, outcomes and logged when statutory bodies and their GP had been informed.

People's needs were thoroughly assessed before a decision was made whether the home could meet the person's needs. A referral to the home was accompanied by a copy of the person's care plan (if hospital/care involvement), physiotherapy, occupational therapy assessments and risk assessments. The registered manager would then complete an assessment either by visiting the person or inviting them to the home. The process of assessment considered all aspects of the person's health and social care needs and support plans were then developed taking into account people's individual needs and goals.

People's physical health needs continued to be monitored and any anomalies were reported to the GP for review and potential referral to other agencies.

Staff received appropriate training which was refreshed regularly in line with changes in legislation. A new e-learning system had been introduced (elfy) which staff could access and detailed required training for completion. Staff spoke positively of the training and support provided to enable them to meet the requirements of the role. Staff said; "All my e-learning is up to date. If not it would flag on the system and the administrator would prompt us to complete it. There is enough training to support us in our role and we are supported to attend external training too" and "The training is very good. More than enough training to do our role."

New staff received a three day induction in to the home and an existing staff member acted as a buddy to support them. All the care staff had completed the care certificate. The care certificate is a nationally recognised set of standards for health and social care workers.

Staff had quarterly supervision. Comprehensive supervision notes were maintained which recorded the one to one discussion and we saw actions from previous meetings had been followed up and fed in to the annual appraisal process. Staff were complimentary of the management and support provided and told us supervision was scheduled for two hours to give them sufficient time to discuss matters. They also said they could request additional support or meetings and these would be facilitated.

The home was spacious and provided ample communal space with access to an outdoor area and smoking room. There was a satellite kitchen people could access to make hot drinks and microwave meals.

Is the service caring?

Our findings

People told us the staff were kind and caring. Comments included; "I like the staff. I feel well cared for", "The staff are nice, caring" and "The staff are very very good. They are absolutely marvellous, they pull out all the stops. They are supportive and brighten up the lives of others."

Staff spoke fondly of people living at the home and told us they enjoyed working at the service. One staff member said, "It's the nicest place I have ever worked. It's a home, a proper family home. I would have no hesitation to have my family member live here." A second member of staff told us, "I love working here. I have been here 20+ years and love what we do with people. Saturday was strictly come dancing and ice cream. It was a lovely evening."

Staff demonstrated they knew people living at the home well. They could describe people's individual needs and preferences. Every person had an allocated keyworker and the keyworker had responsibility for three or four people and making sure their care needs were met and assessments and care records were up to date.

Staff gave us examples of how they had provided support to people's diverse needs including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke with knew the needs of each person well. People using the service also commented on how well their individual needs were met.

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and decision making. The staff we spoke to described the service as promoting choice, independence and control for the individual.

A staff member told us; "We complete the development plan with people. It's a more personal document and focuses on people's individual goals and the support they require to attain them. It's got to be on people's terms, people have got to want it and agree to it to achieve it. Everything here is based on individual choice."

The aim of the development plan was to support people to be as independent as they could. People could live at the home indefinitely but there was also opportunity to develop skills and move on from the home to supported living tenancies. People could maintain their own personal care and were prompted and encouraged to do this. Other activities of daily living encouraged included; putting the cereals out in a morning, making drinks independently, maintaining cleanliness of their room and shopping.

We saw staff were respectful of people's individual needs and provided care and support in a flexible manner. People told us their privacy and dignity was respected at all times and we observed staff knocking on doors before entering people's rooms.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the

service had met this standard. We saw people had communication plans which was the first document within the person's care file. There was nobody living at the home with specific communication needs. However, there was an AIS log in the file and people were asked on admission to develop the communication plan which was reviewed regularly in case people's needs changed. There was an AIS folder in the foyer which contained details of resources to support accessible information. The file was constantly being updated with useful resources, contacts and links.

Advocacy services were promoted throughout the home and these had been appropriately accessed when required.

Is the service responsive?

Our findings

People continued to receive care that was personalised and responsive to their needs. People were engaged with care planning and the care plans in place were person centred and reflected people's individual goals and preferences.

We saw within the care files we looked at there was a significant amount of personal information. This included 'my profile' which provided a summary of people's care needs and detailed things of importance to the person. Biographical information such as; people's hobbies and interests, childhood memories, family, work history, likes and dislikes, dreams and ambitions was also captured. People's preferences, for example preferred bedtime, mealtimes and whether they had a gender preference when being supported was noted.

There was a consistent staff team at the home and many staff had worked there for many years. Staff were knowledgeable of people's needs and when changes occurred they took prompt action and referred people to other health professionals where required.

The staff supported people with daily activities and outings were organised. There was also an acknowledgement that a large proportion of people preferred to watch television in the evenings. This was facilitated at weekends by themed evenings and ice creams and snacks if there was a large number of people that wanted to watch the same programme. People came and went from the home throughout the inspection and friendships and social stimulation was actively encouraged.

There was an open culture at the home. Communication with people and staff was effective and the nature of complaints received was shared with staff and people living at the home. There was a mounted glass cabinet on entry to the home that contained anonymised complaints and service response. We saw there had been two complaints received since our last inspection. The registered manager and staff reflected upon these and had team discussion about possible changes to practice.

The overall outcome of the most recent survey was also contained within the cabinet along with the 30 compliments received since our last inspection. The compliments detailed the relationships people had formed and were expressions of gratitude for the quality of care provided to people's loved ones.

We discussed provision for end of life care at the home. The home is a residential home without nursing so end of life care could only be facilitated if the person didn't require 24-hour nursing. However, if people required nursing intervention that could be planned, the registered manager would access community services to provide time specific nursing intervention. At the time of the inspection there was nobody in receipt of end of life care but there were people living at the home that were considered 'frail'. People's needs were increasing as their physical health deteriorated and the home had equipment ready to support them if required. Staff had received six steps training and there was an end of life champion who attended hospice forums quarterly to keep up to date with end of life care issues. People's wishes for end of life care were documented in an advanced care planning document.

Is the service well-led?

Our findings

There was a registered manager at the home. The registered manager was supported by an assistant manager, senior carers and an administrator. There were suitable arrangements to ensure the effective management of the service. People we spoke with said they thought the home was well run. Comments included; "The manager is brilliant. They will do anything for you" and "The standard of care here is good. I would recommend here to others."

The staff we spoke with were positive in their comments about the management. Comments included; "There is an open culture, the registered manager's door is never shut. I can't fault them, they will drop everything to support us. The training and support I have received has been fantastic. I am proud to work here" and "The management couldn't be more supportive. They are there for you in an emergency and very approachable."

Feedback from stakeholders and health professionals was also positive regarding the quality of care provided to people living at the home.

Staff spoke positively, and with pride, about the service and said they felt listened to and valued. There were monthly staff meetings and they said they were able to make comments and suggestions or could do this with management at any time.

People living at the home were provided regular opportunities to feedback on the quality of care provided through monthly meetings, reviews of the care and annual surveys.

There were visions for the future and development of the use of IT systems. Staff had a training session scheduled on 'palm pilot' which is a handheld device that would contain people's care needs and enable access to programmes to support care provision.

There was an appropriate internal quality audit system in place to monitor the service provided. The audits were aligned with CQC's KLOE's and actions were clearly identified and completed to continue to drive improvements and improve quality. Audits and checks were also completed by another home manager with Making Space to ensure standards were being maintained.

The service was underpinned by a number of policies and procedures which were available to staff.

Providers are required by law to notify CQC of certain events in the home such as serious injuries, deaths and safeguarding related issues. Records we looked at confirmed that CQC had received all the required notifications without delay.

The ratings from the last inspection were displayed in the home entrance which was accessible to all who entered.