Ashmere Care Group

Smalley Hall Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 27 October and 5 November 2015. The first day of the inspection was unannounced.

We had previously inspected the service on 28 June 2014, where we found breaches in the regulations relating to the management of people's medicines, planning and delivery of care, and the provider's systems to assess and monitor risks to people's health, welfare and safety. We asked the provider to send us an action plan to demonstrate how they would meet the legal requirements of the regulation. At this inspection we found that the breaches in regulations had been addressed.

Smalley Hall Care Home provides accommodation for up to 26 older people who require personal care, some of whom have dementia. There were 19 people using the service on the day of our inspection.

The service had a registered manager at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available on our inspection.

Summary of findings

People felt safe at the service, but told us that they did not always feel staff were able to meet their needs in a timely manner.

People were protected from the risk of abuse because the provider took steps to recruit suitable staff.

Medicines were managed and administered by staff with training to do this.

Staff were knowledgeable about people's individual care needs and preferences. These were clearly documented and reviewed regularly.

Staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. Staff sought people's consent before offering care. Where people could not make decisions about their own care, decisions were made in their best interests in accordance with the MCA.

People were not always given additional support to ensure that they had enough to eat. People were involved in making decision about food and drink, and were complimentary about the variety and quality of the food.

Staff knew how to monitor people's ongoing health needs and when to refer them for specialist support. Records of care were clear and detailed, and health professionals felt confident that staff knew how to support people.

We saw staff treat people in a kind and caring manner, and with respect and dignity.

People and their relatives felt that staff did not have enough time to support them in meaningful activities beyond essential care tasks. People were positive about the activities offered by the service, and felt they had opportunities to express their views about their care.

The provider had a range of ways to seek people's views, and people and their relatives knew how to make a complaint. The provider investigated complaints and took action where this was required to improve care.

Quality assurance procedures were in place to identify where the service needed to improve. We saw where these had led to improvements in the service. However, the audits had not identified any issues with staffing levels or how staff spent time supporting people.

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?
The service was not consistently safe.

Staff understood how to recognise suspected abuse and felt confident to raise concerns.

People and their relatives felt that there were not always enough staff available.

Medicines were stored and administered safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were not always given the support they needed to eat and drink. Care plans did not contain adequate information about the support people needed at mealtimes.

Staff completed relevant training and regular supervision to enable them to carry out their roles.

Relevant applications had been made in relation to the Deprivation of Liberty Safeguards, and people's capacity was assessed in accordance with the Mental Capacity Act where this was appropriate.

Requires improvement

Is the service caring?
The service was caring.

People felt that staff were kind and caring, and that they were supported in a respectful way.

People's right to confidentiality was respected.

Good

Is the service responsive?
The service was not consistently responsive.

People's wishes and preferences about their care was recorded, but they did not feel they were supported to do activities they wished to do.

The provider offered a range of activities throughout the week for people to take part in.

The service sought feedback from people and relatives, and complaints were addressed promptly.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

People did not always feel that staff had enough time to spend with them beyond providing essential care tasks.

The provider had effective procedures for monitoring the quality of the service.

Staff felt supported in their work and were confident to raise concerns about the service.

Smalley Hall Care 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 27 October and 5 November 2015. The first day of the inspection was unannounced. The inspection was carried out by two inspectors and an Expert 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. Our expert-by-experience for this inspection had experience of caring for older people with physical health needs. They also had experience of supporting people to access community health services.

Prior to the inspection we looked at information we held about the service. We reviewed our previous inspection records. We looked at information received from local authority commissioners and the statutory notifications the provider had sent to us. Notifications are changes, events or incidents that providers must tell us about.

We spoke with eleven people living at the service, seven relatives and six staff. We also spoke with three health professionals. Not all the people who lived at Smalley Hall Care Home were able to fully communicate verbally with us at the time of our inspection. Therefore, we used the Short Observational Framework for Inspection (SOFI), to capture the experiences of people. SOFI is a way of observing to help us understand how people experience care.

We observed how staff supported people living at the service and reviewed three people's care records. We reviewed other records relating to the care people received. This included some of the provider's audits on the quality and safety of care, medicine records and staff recruitment and staff training records.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the service.

People did not always feel staff were able to meet their needs in a timely manner. One person told us they wished for, "More staff to cut down the time having to wait to go to the toilet" and another said, "More staff to spend time with the residents, more interaction." The views of relatives were mixed. Some relatives felt that staff responded quickly to requests for support with one relative telling us, "It's mostly quick. Just the odd times [person] has to wait for the toilet – they're so busy, [person] has to wait a while." Another relative commented, "They're ok but they are rushed off their feet – it's just when people want them at the same time." Others felt that the provider did not have enough staff available. One relative said, "It's staff levels, especially at weekends. I feel if something drastic happened then there's not enough experienced staff on duty to cope." Another relative spoke about having to go and fetch help for a person who had asked staff five times to support them to the toilet.

We saw staff respond to people's physical needs in a timely way. However, we did not see many staff sitting with people or initiating conversations or activities with them. The provider used a dependency assessment tool to help establish how many staff were needed to support people. The current levels of staffing matched the dependency tool's calculation. The provider's guidance said this should be carried out monthly, but we saw that this was not being done. For example, the assessment was not reviewed between 26 March 2015 and 7 July 2015. This meant that the provider could not demonstrate that there had been sufficient numbers of staff to meet people's needs during this time period. The tool was up to date at the time of our inspection, and evidence showed staffing levels were maintained at weekends. Whilst the dependency assessment tool showed that the service had enough staff at the time of our inspection, evidence from people and their relatives demonstrated that this was not always the case. We have asked the provider to review the individual needs of people and the dependency assessment tool, and to consider how staff are deployed in the service.

Staff knew how to recognise that people were at risk of avoidable harm or abuse. They received training in recognising potential abuse and knew how to refer this to the local authority. There were procedures in place for reporting concerns and staff felt confident to do this. Staff also felt that any concerns they raised about people's safety would be taken seriously. The provider had a policy which guided staff on how to report concerns to the local authority about potential abuse. However, the policy did not contain the most recent guidance from the local authority. We spoke with staff about this and the guidance was updated during our inspection.

We saw risk assessments in place in the records we looked at. These were relevant to the individual. For example in one record we saw records relating to moving and handling, nutrition, pressure sores, falls, choking and dehydration. Another person had their risk assessment and care plan reviewed with them after a fall, and we could see where action had been taken to minimise the risk of future falls. Staff understood what additional support the person needed and we saw them support the person in accordance with the care plan. Risk assessments and care plans were reviewed regularly and updated as people's needs changed. This enabled people to maintain their independence whilst being kept safe from the risk of harm.

Staff understood their roles and responsibilities in an emergency. The provider had essential information about people's needs which was easily accessible to staff in emergencies. This included personal emergency evacuation plans (PEEPs) detailing what level of support people would need if, for example, there was a fire in the building. The provider also had plans to ensure there were alternative accommodation arrangements in the event of an incident which disrupted the running of the service. This meant that people's needs would continue to be met in the event of an emergency.

The provider had a system in place to ensure that equipment was regularly checked and maintained, for example, hoists and equipment used by people to support them whilst bathing. We saw staff support people during our visit, and this was done in a safe way. For example, we saw people use hoists to transfer seating. Staff supporting them used the equipment correctly and spoke with people in a steady and reassuring manner about the process. This showed us that people were supported using equipment that ensured their safety.

Recruitment procedures included checking references, any gaps in employment history and carrying out checks with the Disclosure and Barring Service (DBS) for employees before they started work. Staff personnel files confirmed

Requires improvement

Is the service safe?

that these checks had been done. We saw evidence that staff had changed roles without their employment contracts being updated. The provider had written to staff confirming a change in their role, but did not provide staff with an amended contract. However, we saw that staff had received induction in their new role. This showed that people were protected against the risk of being cared for by unsuitable staff.

People and their relatives felt that staff managed their medication well. We saw staff giving medicines sought people's consent and gave them information about their medicines. Staff checked that people were ready to take their medication. For example, we saw staff check that people had swallowed any food and had a clear mouth before offering people their inhaler. The provider had clear written policies and guidance for staff giving medicines, and only staff trained in safe medicines management gave people their medicines. The registered manager regularly observed staff giving medicines and gave feedback on whether they were doing this correctly. We checked the systems for the receipt, administration and disposal of medicines and saw that this was being done in accordance with professional guidance. However, we noted that the storage of certain medicines was not meeting the standards in the Misuse of Drugs (Safe Custody) Regulations. We spoke with staff about this and this was addressed promptly. This demonstrated that medicines were being managed in a safe way.

Requires improvement

Is the service effective?

Our findings

People told us that they enjoyed the quantity and variety of food offered by the service. One person said, "It's nicely cooked and I can have my own option if I want," and another commented, "I'm happy – there's plenty of it. It's homemade too." Relatives also commented positively about the food, with one relative saying, "It's like a hotel, with a choice of meals. [Person] can eat in the lounge or her room too."

Regular drinks were provided throughout the day and we saw staff frequently encouraging people to have drinks. People had drinks available in their rooms if they wished. We also saw that regular snacks were offered to people between meals. However, people were not always supported to eat in a way that ensured they had enough. When lunch was served on the first day of our inspection there were two staff serving food whilst two staff gave out medicines. We noted that several people struggled to cut up their food, and not all people who needed encouragement and support got this. This resulted in food going cold before it was eaten. Some people were left sitting for over 30 minutes before food was served and one person was left asleep in a chair, so had no lunch. There was little interaction between people and staff apart from practical support to cut up food or to eat. However, on the second day of our inspection, we saw that three staff were available to support people. This meant that people received more support, but several people were still left waiting for staff to encourage or support them to eat and drink in a timely way. People's care plans had little information about the level of support they needed at mealtimes. This demonstrated people were not always effectively supported to eat and drink. This put them at risk of poor nutrition and dehydration.

People were involved in discussion about choices of food and drinks on the day of our inspection. The menu was clearly displayed in the dining room and staff involved people in menu planning. Staff told us that people could have alternatives to the daily menu if they wished, and we saw staff offering people alternatives if they did not like what was being cooked. This meant people were actively involved in planning meals and their views and opinions were sought by the provider.

Staff knew which people needed additional support to eat or special diets, for example, fortified diets or appropriately textured food and thickened drinks. Catering staff were knowledgeable about people's food preferences as well as any specific dietary requirements. The provider had adapted cutlery and plate guards to enable people to eat as independently as possible. We saw that a referral had been made to speech and language therapy (SALT) by a doctor in relation to a person due to swallowing difficulties. The SALT assessment was available and had been incorporated into the person's care records for staff to follow.

People told us that the staff who supported them were trained and experienced enough to meet their needs, with one person telling us, "They all seem experienced." Relatives' views were mixed. One told us that they felt staff were trained and experienced. Another relative commented, "I've concerns on new staff being trained enough. The company doesn't seem to spend a lot on the home and staff, so priorities are wrong."

Staff received an induction in a wide range of care skills, including person centred care, dementia care and safeguarding people. During their induction period, staff were supported by more experienced colleagues. They did not undertake care by themselves until the provider was satisfied that they were competent. All the staff training was up to date and we could see where future training was planned. The registered manager undertook regular supervision and audits of skills with staff to ensure that they were competent. These systems and practices reduced the risk of people being cared for by unsuitable or unskilled staff.

We asked staff to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act helps to safeguard the human rights of people. It provides a legal framework to empower people to make their own decisions, and protects people who lack the capacity to make certain decisions for themselves. The DoLS are part of the MCA. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. Staff told us that they had attended training on the MCA and DoLS and demonstrated an understanding of the process to follow when people did not have the mental capacity to make certain decisions.

Requires improvement

Is the service effective?

Care records documented assessments of capacity and best interest decisions where this was appropriate. We saw evidence which demonstrated that staff considered supporting people in the least restrictive way possible.

The provider had made applications for DoLS authorisations where people's care was restrictive and they lacked capacity to consent to this. This showed that where restrictive care was necessary to prevent the risk of harm, the provider was taking the correct steps to ensure this was done lawfully.

People told us they had the access to health services that they needed. A relative told us that they were happy with the dental service their family member received at the home. People had clear records of their assessed needs and the care plans were reviewed regularly. Records showed us where people's health changed and appropriate healthcare professionals were contacted in a timely manner. Staff were knowledgeable about people's different health needs and what actions they needed to take to ensure people's health was maintained. GPs from the local surgery visited weekly. This demonstrated people were supported to maintain their health and access to appropriate health and social care professionals.

Health professionals told us that staff regularly contacted them for advice, and staff were knowledgeable about people's individual needs. They commented that staff listened to them and they were confident that their advice would be followed correctly. One health professional felt that staff responded quickly to health concerns raised by people or their relatives by contacting them. One person at the home was receiving some nursing care. A visiting health professional said that staff were providing good care and frequently asked for advice about how to support the person. We saw clear records of the person's daily condition and guidance for staff on providing care.

Deteriorations in people's health were monitored, including behaviour that was unusual for people. Staff told us that changes in behaviour could indicate an underlying health problem or that people were unhappy with something. The provider had a system in place for monitoring behaviour if this was needed, and this helped staff to understand what was happening and take appropriate action.

Good

Is the service caring?

Our findings

People told us that they found staff friendly and caring. One person said, “They’re very good. I feel confident.” People felt that staff respected their privacy and provided care in a dignified way. Most relatives we spoke with also felt that people were treated in a caring and respectful way.

Staff demonstrated they knew how to provide care in a dignified way. For example, we saw several people being supported to use the toilet throughout the day. Staff communicated with them in a quiet and tactful way to minimise the risk of other people overhearing these conversations. Staff made sure toilet doors were locked when they supported people, and took care to ensure people’s clothing was properly adjusted afterwards.

One relative commented they felt that staff were sometimes not as respectful as they could be, for example, when staff turned the television over without asking people if they were watching it or what they would like to watch, or when people’s clothing got mixed up. However, we saw staff interacting with people throughout the day to offer care in a kind and thoughtful way. For example, staff fetched a blanket for one person who was cold, and then went back to check on them later.

People were not always aware that they were involved in making decisions about their care but evidence we looked at demonstrated that people’s views and opinions had been sought. One person spoke with us about their care planning, stating, “I can ask to see my care plan when I want as I’m independent. I feel fully involved.” Relatives expressed mixed views on being involved in people’s assessment and planning of care. One relative said “I’m kept up to date on her care,” but another said, “I’ve never been involved with [person’s] care plan.” Staff told us that they tried to involved relatives in care planning where appropriate, but this was not always possible.

A relative observed that staff did not wear name badges and said this was potentially confusing for people at the home. Staff told us that they were not currently given name badges, but that the provider was planning to change this in future. The provider’s area manager confirmed that this was the case. This meant that there was a risk that people with memory problems would have difficulty recalling staff names.

The provider had secure storage for records relating to people’s care, and access to these was restricted. When staff spoke with people or to each other about people’s care needs, they did so in a way that was mindful of people’s right to confidentiality. This showed us the provider took their responsibility to maintain people’s privacy and confidentiality seriously.

Requires improvement

Is the service responsive?

Our findings

People told us they were supported to make choices about their daily care routines. For example, people were able to choose when to get up, what clothing they wished to wear, what activities they wanted to take part in and where to have their meals. However, people felt there were not enough staff available to enable them to do the things they wished to do.

Relatives told us that, whilst staff were caring, they did not appear to have time to support people in meaningful activities beyond essential care tasks. One relative said, "Enough staff, but they do not go and sit with and talk to people when they have time to do so" and another commented, "They're not really trained enough in interacting with the residents – just the physical needs." One relative noted that their family member could be more independent than they were, for example, if the toilet bins were easier to open to dispose of continence products. The relative said that their family member struggled with this and therefore staff supported them when they did not need to. This meant people were not always supported to maintain their independence.

We saw that not all staff took opportunities to spend time engaging with people in a more conversational way on a one to one basis. A lot of the interaction we saw was very focussed on the task of care. This meant people missed out on opportunities to have more meaningful conversations with staff, for example, about activities, families, and things that were important to them.

People's individual care needs were known to staff and reflected what we found in people's care records. Staff were able to tell us about how people liked to be supported and what health conditions meant for people. For example, two staff were knowledgeable about one person's history of falls and how to best support the person. Another staff member was knowledgeable about people's diabetes and how their diet needed to be monitored. Staff shared information about people's care needs on a daily basis. Relevant notes were made of needs and we could see where staff have taken action to ensure care was provided.

People spoke positively about the activities that the provider offered, "We have a morning singalong or quiz usually, then maybe afternoon crafts in the activity room. We've had outings to a garden centre, to Matlock and drives around countryside." Relatives were also complimentary about the variety of activities offered, but a relative commented on the patio garden area being underused. A relative also expressed concern that people who chose to sit in the conservatory were not supported in the same way to take part in activities. Staff told us that the provider was in the process of developing the patio area to improve access and create an outside place for people to sit. Records showed us that people were supported to take part in a range of group activities throughout the week, including having visiting entertainers and trips out.

On the first day of our inspection, the activity coordinator was not available, but on the second day, staff were supporting people to take part in games and a singing session. However, for much of our inspection, people in communal areas of the home did not receive much support to engage in activities or conversations. We noted that most of the staff support was directed towards people in the lounge and dining room. Those people who were sitting in the conservatory and adjacent alcove did not receive as much support. This showed us staff were not deployed effectively to enable them to develop relationships with people and support them to maintain their independence.

Staff were sensitive to people's communication needs. For example, staff could describe how one person non-verbally indicated they needed the toilet and how staff responded. We saw staff notice the person's body language and support them. Staff were knowledgeable about how to support people with making decisions about their care and daily activities. Staff understood why personalised care was important to people, and knew what this meant for individual people.

People and their relatives felt able to raise any concerns and complaints about their care. One person commented, "I've had to mention the odd thing but am always told the outcome." People and relatives knew about the complaints procedure and some relatives spoke about complaints they had made. One relative said, "We had a complaint a year ago soon [relating to their family member spending a lot of time in their wheelchair]. So we said something and it got better after that."

Requires improvement

Is the service responsive?

The home kept a record of complaints. We saw that the home had responded in a timely manner and had recorded actions taken to address complaints. There was a complaints policy in place and evidence showed the provider had followed this.

People told us that they had residents meetings where they were able to talk about the service. One person said, "We have occasional residents' meetings – are we satisfied with the care, our meals, any changes we want and so on." Relatives were able to give feedback to the provider in a variety of ways, for example, annual surveys, meetings at the home, suggestions box at the service and via the provider's website. A relative commented "There's a suggestions box in the hall. We've no fault at all with the place though." However, another relative felt that the meetings were not accessible because they were held during the day when they were at work.

We saw that the provider regularly asked people and their relatives for feedback about the quality of the service. There were regular meetings for people where they were able to express views about the service. The records showed, for example, that people shared their views on activities, menus and improvements to the service. This demonstrated that the provider had a range of methods to seek views of people and relatives about the care, and had systems in place to communicate what actions were taken as a result of feedback.

Requires improvement

Is the service well-led?

Our findings

On this inspection we identified concerns relating to staffing levels. The provider's assessment of people's dependency levels and associated guidance on staffing levels determined that there were enough staff employed on each shift. However, evidence from people, relatives and our own observations on the inspection indicated that people's needs were not always met. People had varying levels of support to engage in meaningful conversations and activities and this had an impact on their well-being.

Audits were carried out regularly to monitor the quality of the service and to identify how the service could improve. These included health and safety, building and equipment maintenance, standard of care records, and medicines. The provider was undertaking a programme of improvement, including garden access, redecoration, new bathrooms and new carpets. However, these audits had not identified any issues relating to the deployment of staff in the service.

There were opportunities for people, relative and staff to provide feedback about the quality of the service. Staff were able to raise concerns or suggestions for improving the service. The registered manager held regular staff meetings and we could see where staff raised issues of concern or suggestions for improvement. The records also showed us that the registered manager was doing regular audits of the quality of the service and we could see what the provider's response was.

The service had a registered manager in post and people and relatives knew who they were. People felt that they could speak with the registered manager about their care, with one person observing, "The manager's very approachable." Relatives had mixed views about the way the service was run. One relative said, "It's a better run place now under [registered manager]. She's more business-like."

Staff understood their roles and responsibilities and felt supported in their work. They were confident in raising concerns about care or making suggestions to improve the service. They felt they would be listened to. This showed us the provider supported staff to question practices at the service.

The service had appropriately notified the Care Quality Commission of any significant events as required. We were unable to speak with the registered manager, but senior staff were knowledgeable about when to submit notifications and why this was required.

Incidents and accidents were recorded and analysed to see how risks could be reduced. We discussed this with senior staff, who showed us evidence to demonstrate what changes they had made in the service to improve the quality of care and reduce the risk of harm.

We looked at a sample of policies and found that these were comprehensive. However, they did not always reflect the most up to date professional guidance. We raised this with staff and the provider updated these during our inspection.