Barchester Healthcare Homes Limited

Ashlar House

Inspection report

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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

Ashlar House is a 'care home'. People in 'care homes' receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. Both were looked at during this inspection.

Ashlar House is registered to provide accommodation to up to 36 people who are living with dementia. It is located in the grounds of St Margaret's hospital in Epping and provides nursing care. At the time of inspection there were 35 people living at the service. People's accommodation was situated on one floor.

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 operations manager for the provider was currently in the process registering as the manager as the previous manager had left the service.

At our last inspection in March 2017, the comprehensive the overall rating for this service was Requires Improvement. A breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 was identified. This was because people told us there was not enough staff. At our last inspection, we also identified other areas they needed to improve, staff refresher training was overdue, staff had not received a recent appraisal and people were not always supported to take part in activities. The registered provider sent us an action plan detailing the improvements they would make. They kept us informed of their progress.

Staffing levels had improved since our last inspection and people's needs were now met in a timely manner. The provider completed relevant pre-employment checks to ensure staff were safe to work with older people. Medicines were managed safely and administered as prescribed.

The staff received training and support to ensure they had the skills to provide people's support in a safe way. The provider kept an overview to ensure refresher training, supervision and appraisals were kept up to date.

People were provided with activities and entertainment of their choosing and regularly accessed activities within the community. People knew how to raise concerns and were confident any concerns would be listened and responded to.

There were systems in place to minimise risks to people and to keep them safe. When we identified a concern related to one person's behaviour support plan and risk assessment the provider responded immediately. People were relaxed and at ease in their surroundings and told us they felt safe. Procedures were in place, which safeguarded the people who used the service from the potential risk of abuse.

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. Staff worked closely with healthcare professionals to promote people's well-being, and make sure health needs were monitored. People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People had the opportunity to give their views about the service and feedback was acted upon in order to ensure improvements were made to the service when required. The service had a robust quality assurance system and identified shortfalls were addressed.

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 were supported by staff who had received training in how to safeguarding people from abuse were aware of the risks to them.

People were supported by sufficient numbers of staff who had been safely recruited.

Systems were in place to ensure people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet people's needs effectively.

The service was up to date with the Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services, which ensured they received on going healthcare support.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

There were a variety of activities for people to take part in.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well-led.

Changes in the management had taken place and the provider was active in trying to recruit a registered manager.

People were asked for their views about the service and their comments were listened to and acted upon.

The service had a robust quality assurance system and identified shortfalls were addressed. As a result the quality of the service was continually improving. This helped to ensure that people received a high quality service.

Ashlar House

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 09 and 11 May 2018 and was unannounced. The inspection team consisted of two inspectors, an Expert by Experience and a specialist professional nurse advisor. The nursing advisor was used to check people's health and care needs were met in a safe and effective way. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR 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 PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales.

We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection. During the inspection, we spoke to five of the people living in the service and 14 of their relatives. We spoke to nine members of care staff, three nurses on duty, the operations manager and the deputy manager. We also spoke with two visiting healthcare professionals.

We looked at a sample of care records belonging to ten of the people who used this service and we observed staff supporting people with their day to day needs in communal areas. We looked at the recruitment records of three staff, the staff rosters and staff training records. We checked maintenance records and quality assurance audits the provider had completed.

Good

Is the service safe?

Our findings

At our last inspection in March 2017, we found there were not always enough staff on duty to meet peoples care and support needs. At this inspection, we found staffing levels had improved. People who used the service and relatives told us the service had sufficient staff deployed to meet people's needs. One person told us, "It is not too bad, staff are pretty good, they are pushed at times, and busiest time is meal times." A relative said, "I change my pattern of visits and sometimes it is 9.45 in the evening, there are visible staff sitting around with music playing and I feel [family member] is safe and I am at peace."

There was some feedback from relatives related to lack of staff particularly first thing in the morning. One relative told us, "Sometimes not quite enough staff, mornings occasionally very short staffed, been better last couple of months." The operations manager continued to monitor staffing at busy times.

Staff told us there were enough staff employed at the service. One staff member told us, "There are enough staff unless people are off sick but then they get agency cover so we might be short for an hour." Another staff member said, "Yes definitely enough staff, we are a good team and they are all lovely."

When people were unable to use their call bell to ring for help, there were management plans in place, which meant staff checked on them regularly, to make sure their needs were being safely met.

Safeguarding and whistleblowing procedures were in place to protect people from the types of abuse that can occur in care settings. Staff confirmed they had received training in how to safeguard people from the risk of abuse; they knew the signs to look for and understood the reporting process. Staff were familiar with the whistleblowing policy and told us they would feel confident to whistle blow and they would be listened to and their concerns actioned.

Risk assessments were completed and regularly reviewed, which provided guidance to staff on how to support people to stay safe. Risk Assessments were tailored to each individual person to reflect risks that were unique to them. For example, one person had a risk assessment for refusing to wear shoes, staff were reminded to regularly check the person's feet and heels.

Staff demonstrated a good awareness of risks to people and knew how to manage them. One staff member told us, "[named person] gets lots of urine infections and we always encourage fluid."

Where people were at risk of falls, a falls diary was kept and analysed and appropriate action was taken. For example, where it had been identified, a person had fallen three times in a month; the GP was contacted to arrange a referral to the falls prevention team.

However, we did observe one example where risks not well managed. The person had their door wedged open with a cushion, which they walked over as they went in and out of room. This had potential to be a trip hazard. We discussed this with the operations manager and an updated risk assessment was sent to us following this inspection, which included guidance for staff in how to manage this.

We observed a person who was receiving 1:1 care from an agency staff member as they were in danger of slumping forward in their chair. They told us, "We look to see how alert [named person] is to decide if they are having a good day and can sit out in their chair." They were able to identify the risks to the person and knew how to manage them. They told us, "We check footwear to make sure they are not wearing socks when they stand up and it is always two of us to help them to stand. We make sure they wear a neck brace as this stops their head going forward and helps them with eating and drinking." This demonstrated agency staff were provided with a good handover to support them to provide care that met peoples individual care needs.

Nurses were responsible for all administration of medicines at the service and all medicines management. We observed a registered nurse on part of a medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to and their practice was seen to be safe. The pharmacy provider had just completed an audit and no actions had been required. We also talked to a pharmacist working with the service from the clinical commissioning group who was supporting the surgery with medicine reviews for the people that used the service. They told us, "I cannot fault the service, the deputy manager is working with us to improve the systems between the surgery and the service. They are trialling an on line ordering system and this is working well. The service is demonstrating a willingness to get things done." A relative told us, "Meds were just reviewed, Staff thought they had thrush so seen doctor who checked them today and they have now got cream. This is 5 star – staff friendly and a nice atmosphere."

Premises and equipment were managed safely. All equipment was checked and serviced regularly. Fire checks were carried out and there were records to demonstrate the service had regular fire drills and training.

People commented positively on the cleanliness of the environment. One relative said, "Yes nice and clean, very nice, friendly staff, most days am here lunchtimes to help with feeding which can take up to 1.5 hours. " Another relative said, "Cannot fault this home, friendly and people talk to you, it is clean, residents all looked after, bedroom is clean and tidy, it is clean throughout." We observed people were protected from the spread of infection and staff wore gloves and aprons when providing personal care. Staff advised PPE was available for them to use and we observed the home to be clean and odour free. Cleaning schedules and rotas were in place and a team of housekeeping staff supported the service.

Records seen indicated accidents and incidents were reported, recorded and reviewed. There was evidence action was taken in response to accidents and incidents. Staff told us they had opportunity to learn from incidents that had occurred at the service and records from staff meetings demonstrated concerns had been discussed. All accidents and incidents were recorded on an electronic system and the provider's quality and clinical governance team monitored these to ensure appropriate actions were taken.

Good

Is the service effective?

Our findings

At our last inspection in March 2017, shortfalls were identified in refresher training for staff working at the service at this inspection we saw the operations manager had a robust system in place to monitor staff training and support.

When new staff joined the service they received an induction. This included completing the Care Certificate, which represents a set of quality standards care staff should apply in their daily practice. This involved completing a range of mandatory training which was provided via e-learning and then face to face in a classroom setting. New staff were also given the opportunity to shadow staff that were more experienced so they could learn about their role and get to know the needs of people before providing care and support.

Staff confirmed they had received practical manual handling training so they could learn how to safely move, and position people. Staff were able to identify those people at risk of falling and knew what to do to help them move around the service safely. For example, one staff member told us, "[named person] is at risk of falling when they sit down; we make sure we are there to support them as they can miss the chair or bed and fall." This information matched what we found in the person's care plan, which demonstrated staff knew people well. During this inspection, we did observe one inappropriate manual handling move by two members of staff, which we discussed immediately with the operations manager. They explained the physiotherapist was working with this person due to the difficulties staff were having with moving them and they had advised best practice. The operations manager responded immediately and told us following the inspection they had met with the staff members and further training had been booked, the operations manual handling trainer would also be monitoring their practice.

Nurse working at the service were provided with additional training to support their professional development such as end of life care training, syringe drivers and catheterisation. One nurse stated. "The deputy manager is superb and very supportive, and carers are really, really good and hardworking."

Staff told us they received regular supervision. This was an opportunity to discuss any concerns, training needs or any other support required. Staff we spoke with told us they felt well supported. One told us, "We get feedback and learn something we didn't know before, it's good."

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. We found the service was working within the principles of the MCA.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The service had applied to the local authority for DoLS authorisations, some had been granted, some were waiting for the authority to assess the person and their

situation.

Mental capacity assessments were completed however these were variable in quality. We saw one, which was very detailed regarding supporting someone who self-neglected with their personal care, this one included the views of the family and documented the past wishes of the person. We also saw one, which was not so clear about who had been involved in the best interest decision making. We discussed this with the operations manager who told us they would review all mental capacity assessments.

Staff understood how to support people who might have difficulty making decisions and comments included, "I show [named person] different outfits to help them choose, if they smile then I know they like it" , "We always ask people what they want, we give them choices and get people involved and give them opportunities."

Consideration had been given to people's mental health and wellbeing. People identified at risk were screened to check whether they had depression and to assess their wellbeing. Whilst this represents good practice when caring for people living with dementia we found the assessment tools were not always well applied as the results did not always accurately reflect the person. For example, we saw one person who was recorded as often expressing suicidal thoughts, had been assessed and scored as not having any suicidal feelings.

We recommend that the systems and processes for assessing people's risk of depression and ill-being be reviewed to ensure people's mental health needs were being met at all times.

When people displayed behaviour that challenged, this was not always well managed by staff. We spoke with three staff who told us they had not received any training in how to manage challenging behaviour. We saw one person who became increasingly agitated over time. Staff attempted to use distraction techniques but the person's behaviour continued to escalate. We observed one staff member talk to the person sternly. A nurse then arrived, we found their approach, and technique to distract and minimise the person's distress was excellent, the person responded positively to the nurse and very quickly became less distressed.

We reviewed the person's care plan relating to their mental health and found it lacked detail. For example, it did not mention certain repeated behaviours or the triggers for the behaviour or provide sufficient guidance for staff on how to diffuse situations. Senior staff informed us about the triggers for this behaviour but this information had not been included in their care plan. However, three out of four of the staff we spoke with were aware of the triggers and could describe techniques they used to support the person to remain calm. One staff member told us, "[named person] gets agitated but if you talk to them about something else it distracts them." The operations manager acted promptly following our feedback related to this incident, they sent us a copy of the training course 'distressed reactions' the company trainer had delivered to staff following the inspection. An updated care plan for behaviour was also sent to us that included detailed guidance for staff. The person had been referred to the specialist mental health team for a further review of their care.

A pre-admission assessment was completed which provided a holistic picture of people's needs including physical, emotional, cultural, spiritual and social needs.

People were supported to have their healthcare needs met. We saw people had been seen by falls prevention, the GP, dietician, the chiropodist and optician. We observed staff followed advice given by health professionals. For example, where a person with diabetes had refused breakfast, we saw staff encouraging the person to drink a food supplement as per the district nurse's advice.

People were supported to have enough to eat and drink. Where it had been identified people were at risk of malnutrition, a referral was made to the dietician and people were provided with fortified meals and weighed weekly to closely monitor their progress.

We observed the mealtime experience at lunchtime where a three-course meal was provided. The tables were nicely laid out with fresh flowers and tablecloths. People all had drinks, and condiments were made available. Staff offered discreet assistance to people with cutting up their food if required. Some people were provided with assistance to eat and drink by staff. The provider carried out twice-monthly audits in relation to the dining experience to monitor the standards in relation to nutrition and presentation.

People were positive about the food provided at Ashlar House and one relative told us, "Food is very nice, they have a pureed diet and I taste it and it tastes nice and is displayed nicely, there is a little kitchen for us (relatives) to help ourselves to tea and coffee." Another relative said, "Food is very good, always a drink in the room."

The environment had been suitably designed to meet the needs of the people who lived at the home. The accommodation was on one level, which meant people could move around the service freely and access outdoor spaces at any time. People's rooms were personalised and we saw in one room where family photographs were on display so the person could see them from the bed. Information on the walls in the room stated which song the person liked as well as other likes and dislikes such as "likes being wrapped up warm and sitting out in chair". Free Wi-Fi was available throughout the building for people and their relatives to use.

Good

Is the service caring?

Our findings

At the last inspection the service was good, at this inspection the service remained good.

Feedback from people and relatives was very positive. One relative told us, "I said today, any chance you can help me get [family member] out of the armchair and take them out into the garden, I got speedy attention today and that is what I usually get." Another relative said, "Staff seem very nice, very pleasant and helpful."

Staff knew people well and interactions between people and staff were seen to be very positive. We observed the interaction between staff and people when providing one to one care. Staff understood their role was to engage with people rather than simply supervise them. We saw an agency staff member who was responsible for providing one to one care and support to a person. We saw them laughing and chatting with the person. They offered the person choices and attempted to keep them engaged, offering to take them into the garden and talking about things that interested the person such as their family. The staff member told us, "I will talk to [named person] and stroke their face to try to find out what they want to do." We observed this in practice throughout our inspection and saw the staff member was warm and affectionate using touch appropriately to interact with and stimulate the person. We observed another staff member kneeling in front of a person in an armchair zipping up their cardigan, thy maintained good eye contact and asked the person, "Do you want to go to the day centre today."

The service gathered information about people's culture, which helped protect their sense of identity. For example, one person's care plan stated, "I love Christmas, making sausage rolls and mince pies." Spiritual meetings were held weekly and all faith denominations were invited to attend. In the PIR the service had recorded they were aware of the Dementia Alliance campaign to improve care and support for people affected by dementia from seldom heard groups such the Lesbian Gay Bisexual & Transgender (LGBT+) community and were encouraging staff to have an awareness of these issues should they require this knowledge in the future.

The service listened to people and included them in care and support planning. We saw people had an annual review of their care plan at which time the views of the person and their family members, if appropriate could be expressed and documented. Regular meetings were held with relatives and experience cards were available for people and relatives to use anonymously if they preferred. Relatives told us they felt welcomed at the service and could join or support their family member at mealtimes. The operations manager told us 15 family members had joined them for lunch at Christmas.

The service supported people to communicate their needs. People had communication care plans, which identified any sensory needs and provided guidance for staff on how best to communicate with people.

People's care plans identified their strengths and abilities and described what people were able to do for themselves. This guidance helped staff to support people to be as independent as they could be. We asked staff how they supported people to remain independent. One staff member told us, "It's the everyday tasks like drinking tea with [named person]. I put their hand round the cup so they feel like they are doing it."

Staff treated people with dignity and respect and demonstrated positive values such as calling people by their preferred names, knocking on doors before entering and asking people for permission before providing care. Staff described how they maintained people's privacy and dignity when giving personal care. One staff member told us, "We always shut the doors and curtains and keep people covered with a towel and describe what we are going to do to make sure they are ok with it."

Good

Is the service responsive?

Our findings

At our last inspection in March 2017, opinions were mixed in relation to the activity provision at the service, at this inspection people told us this had improved. People had activity plans which identified what people liked to do and how often. During our visit, we observed the activity organiser talking to people and encouraging them to join in the morning's activity. We saw people had various things they were doing. One person sat with an activity board of bolts and locks, which was dementia friendly and helping the person to remain occupied. Other people were reading newspapers or chatting to staff.

We spoke with the activity organiser who showed us the events on the engagement board, these included what was happening and photographs of previous events. The activity organiser said, "This board is the community engagement board, it shows our Mother's day event where a local florist donated baskets and we put daffodils in and gave one to every resident." Other events included a local church market and coffee morning, visiting entertainers and church visits. A music therapist also regularly visited the service and played music for people, on the day of our visit we observed this and saw people and relatives joining in whilst the therapist went from person to person. People were positive about these improvements and one relative said, "[Family member] likes the entertainers." Another relative said, "They like to be out with people, the activity lady is very good, [family member] liked Valentine's day and likes the activity lady reading the newspaper to them."

The service now had an activity team working at the service and the other activity staff member told us, "Easter was a nice high point, we factor in capacity and try to make sure everyone can take part, we placed eggs around the building for people that were able to walk and made Easter bonnets for others."

Staff knew people well and were responsive to their needs. One staff member told us, "[named person] loves jelly so much and fizzy drinks but they must be cold, they also love tomato soup." Another staff member said, "[named person] doesn't like too much noise but we open their windows as they like to listen to bird sounds."

Care plans provided sufficient guidance to support staff to deliver person-centred care. Person-centred care is care that is tailored to each person's individual needs, and recognises that everyone is different. People's care plans included information about their life history, likes, dislikes, routines, preferences and family tree. This information helped staff to provide care and support the way people wanted.

Staff demonstrated they understood and respected people's routines and preferences. A staff member told us, "It's their time, not ours, they are not at work, it's their home so we do things how they want them." Written records confirmed people were receiving care and support that reflected their routines and choices. For example, one person's care plan stated they enjoyed sitting at the nurse's station in the evening having tea and biscuits. We looked at the person's daily notes, which showed this was how the person usually spent their evenings.

The provider had systems in place to deal with any concerns or complaints. The people we spoke with told

us they were confident any concerns would be appropriately dealt with. One relative said, "They are quite good and if I am not happy about staff I go and tell the Deputy or temporary manager or tell the nurse and they say we will deal with it and they do." Another relative told us, "When I come in they will say they have chased up this or that, they do involve me." We saw the operations manager had investigated and responded to any complaints within agreed timescales and to the satisfaction of the complainant.

If people had particular wishes for their end of life care these were explored, documented, and kept in people's care plans so people's wishes were known and respected. The operations manager shared with us a new personalised plan of care for supporting people in the last days and hours of their lives. They planned to introduce that included sections to be completed by any other professionals involved at the end of a person's life.

Good

Is the service well-led?

Our findings

The operations manager for the provider was currently in the process of completing their application to register as the manager. They told us they took the recruitment of the registered manager very seriously and had not yet found a suitable person to take on the role and recruitment was continuing. The operations manager was actively managing the service and told us they were happy to remain for a year if a suitable replacement could not be found.

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.

At our previous inspection in March 2017, the service had identified the shortfalls we found but had not had time to implement the required improvements, at this inspection we found the improvements had been made. We also identified some improvements needed at this inspection and found the operations manager very responsive in the actions they took to address these issues. Information was sent to us following this inspection, which was comprehensive and included what had been put in place to sustain these improvements.

The operations manager was very visible in the service and it was evident that the people who lived there knew them well. A deputy manager also supported them and feedback was positive about their leadership of the service. One staff member told us, "The management are very nice and supportive, they think about us." Another staff member said, "Management are lovely, so supportive; we are a good team; everybody will muck in and help out." A third staff member said, "I am very much supported by management, got deputy who is very approachable, the Managing Director is amazing, we are all singing from the same hymn sheet." People were cared for by a team of staff who were well supported. Staff had the opportunity to discuss their role, performance and training during regular one to one sessions with senior staff.

To promote positive values and ensure good practice was recognised the service operated a carer of the month scheme. Staff were nominated by people and their relatives who used the service. We spoke with the staff member who had been nominated this month. They told us they had been given the award for interacting with and including relatives in decision making around people's care and support.

There were audits and checks in place to monitor safety and quality of care. In addition to audits carried out by the operations manager, audits and visits were carried out by the provider's quality team and regional director. We saw where shortfalls in the service had been identified action had been taken to improve standards and practice. For example, improvements to staff files had been identified and this had been signed off as completed. Clinical governance information was collated on a monthly basis and used to make any changes to practice might be required.

Healthcare professionals we spoke with told us the service worked in partnership with them to ensure

outcomes for people were positive. One healthcare professional said, "No concerns with care so far, they are very good here."

People and their relatives had opportunities to express their views about the quality of the service they received through regular meetings and satisfaction surveys. People and their relatives were positive about the service, One relative told us, "It has got a nice ambiance here, I came unannounced (last autumn) and a staff member from the laundry showed me around, had not booked in but it had a great feel about it, they really accommodated me. Full of life here, people here are living with dementia not dying with dementia, there is life in this home." Another relative said, "It is a small home, clean, staff are nice, cannot understand why they cannot keep a manager, the acting manager is doing well and they do try and get people involved." A third said, "Would recommend it, and I would not put the local location over the care, absolutely the care is first."