Ashfield Specialist Care Limited

Ashfield Nursing 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 and 17 May 2017 and was unannounced.

The provider is registered to provide accommodation for up to 40 older people living with or without dementia in the home over two floors. There were 35 people using the service at the time of our inspection. The home provides nursing care.

A registered manager was in post; however, they were no longer working at the service and had submitted an application to cancel their registration for the service. The service was being managed by two managers from other homes owned by the provider. Both managers were present on the first day of inspection and one of the managers was also present on the second day of the inspection. We were told that the new manager would be appointed shortly and they would apply to be registered for this service when in place. 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.

Safe medicines and infection control practices were not always followed by staff.

Staff knew how to keep people safe and understood their responsibility to protect people from the risk of abuse. Risks were managed so that people were protected from avoidable harm and not unnecessarily restricted. Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices.

Staff did not receive appropriate training and appraisal. Supervisions were not taking place for all staff. People's needs were not fully met by the adaptation, design and decoration of the service.

People's rights were protected under the Mental Capacity Act 2005. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. However, advocacy information was not available to people.

People received care that respected their privacy and dignity and promoted their independence.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though activities could be further improved so that more people could access activities outside the home.

Complaints were handled appropriately. A complaints process was in place and staff knew how to respond

to complaints.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. As a result the provider was not fully meeting their regulatory requirements.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, actions did not always take place promptly in response to people's comments.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Safe medicines and infection control practices were not always followed by staff.

Staff knew how to keep people safe and understood their responsibility to protect people from the risk of abuse. Risks were managed so that people were protected from avoidable harm and not unnecessarily restricted.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive appropriate training and appraisal. Supervisions were not taking place for all staff.

People's needs were not fully met by the adaptation, design and decoration of the service.

People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink. External professionals were involved in people's care as appropriate.

Is the service caring?

Good

The service was caring.

Staff were kind and knew people well.

People and their relatives were involved in decisions about their care. However, advocacy information was not available to people.

People received care that respected their privacy and dignity and promoted their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs. Care records contained information to support staff to meet people's individual needs, though activities could be further improved so that more people could access activities outside the home.

Complaints were handled appropriately. A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems were in place to monitor and improve the quality of the service provided, however, they were not fully effective. As a result the provider was not fully meeting their regulatory requirements.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, actions did not always take place promptly in response to people's comments.

The registered manager was no longer working at the home and the management position was being covered by two managers. A manager was to be appointed shortly.

Ashfield Nursing 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 16 and 17 May 2017 and was unannounced.

The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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.

Before the inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with nine people who used the service, four visiting relatives or friends, the head cook, a domestic staff member, the housekeeper, the maintenance person, the activities coordinator, three care staff, a nursing assistant, a nurse, the administrator and one of the covering managers. We looked at the relevant parts of the care records of nine people who used the service, three staff files and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt the home was safe. A person said, "I feel very safe." Another person said, "This is a very safe place." A visitor said, "This is a lovely place. I had real reservations about [my family member] coming here because I had another relative here ten years ago and the care was dreadful but it's a different place now and he is definitely safe."

Staff were aware of safeguarding procedures and the signs of abuse. A safeguarding policy was in place. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. Appropriate safeguarding records were kept by staff of any safeguarding referrals they made and appropriate action had been taken to reduce further risks. However, a number of staff had not received safeguarding training. We raised this with management who told us that training for all staff in all areas was being arranged as a matter of urgency.

People told us that they were safe and were not unnecessarily restricted. A person said, "I can please myself." Another person said, "I can't walk but the staff take me wherever I want to be. I come in here [the conservatory] in the morning and then after lunch I go for a bit of a lie down. It's always up to me."

People told us and we observed that staff supported them to move safely. Risk assessments were completed to assess risks to people's health and safety. These included whether staff should administer a person's medicines, risks of moving and handling, falls, nutrition, and pressure ulcers. When bedrails were used to prevent a person falling out of bed, risk assessments were completed to ensure they could be used safely.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans and the involvement of external professionals. Accidents and incidents were analysed to identify any trends or themes so that actions could be taken to reduce any risks of them happening again. This included referring to external professionals for guidance.

Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers and they were functioning correctly. We saw that records showed that a person received support to change their position to minimise the risk of skin damage in line with their assessed needs as set out in their care plans.

Staff told us they were able to obtain any equipment people required and they said they had sufficient equipment, such as moving and handling equipment, to meet people's needs. We saw that the premises were safe and well maintained and most checks of the equipment and premises were taking place. However, fire drills and recent servicing of the emergency lighting had not taken place. Management took action to address these issues during our inspection.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for all people using the service. This meant that staff would have

sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place; however, it required further detail to provide sufficient guidance for staff to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People told us there were sufficient staff on duty. A person said, "[Staff] are always around." A visitor said, "My relative has never complained about having to wait for help." Another visitor said, "There is enough staff as [my family member] always needs two [staff] and there is never a problem."

Care, laundry and kitchen staff all felt that they were busy but had sufficient time to complete their work effectively. Domestic and activity staff felt that additional staff would allow them to better meet people's needs in these areas. During the inspection we observed that the number of staff available was sufficient to enable a timely response to people's requests. Staff monitored the communal areas of the home and when they saw people trying to get up who were unsteady on their feet, staff quickly responded to assist them or encourage them to sit down. At lunchtime there were sufficient staff to enable people to be served and assisted in a timely way. People who were allocated one to one care received it.

Systems were in place to identify the levels of staff required to meet people's needs safely. People's dependencies were considered when setting staffing levels and staff levels were monitored closely to ensure that the correct level was maintained. A staffing tool was also completed which concluded that sufficient numbers of staff were on duty to meet people's needs safely.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

A person said, "[Staff] watch me while I take the tablets and bring me some water with them." Staff told us they had completed medicines training and had their competency assessed to administer medicine.

We observed the administration of medicines during the morning and at lunchtime on the first day of our visit. We saw staff checked against the medicines administration record (MAR) for each person and stayed with people until they had taken their medicines. However, during the lunchtime medicines round, one staff member took the medicines for each person and put them in a medicines pot and another staff member took the medicines to each person and stayed with them until the person had taken their medicines. As a result, several medicines were "potted up" at one time, and a different staff member administered the medicines to the staff member that had checked the medicines against the MAR. This practice increased the risk of errors occurring and the person responsible for administration of each medicine was not clear. We raised this management who told us that they would take immediate action to address this issue.

MARs contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines. We checked MARs and found they had been fully completed. Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner and we did not find any evidence of gaps in administration of medicines due to a lack of availability.

Medicines were stored securely in locked trolleys, cupboards and a refrigerator within a locked room. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. When medicines were prescribed to be given only when required protocols were in place to provide staff with guidance on when to administer the medicines. When medicines were given covertly a full assessment had

been completed and approval had been given by the person's GP and pharmacist. Covert medicines are medicines disguised by being given in food or drink.

People told us the home was clean. A person said, "My bed is clean." A visitor said, "Everything is very clean. [My family member]'s room and bed are always immaculate and there is no smell." Another visitor said, "They work very hard to keep everything clean. I have no worries about that."

During our inspection we looked at some bedrooms, all toilets and shower rooms and communal areas and found that the internal environment was generally clean though some equipment needed cleaning. We also saw that a person who used the service dropped unhygienic items out of their first floor bedroom window. On the first day of our inspection we saw that there were lots of these items on the grass in front of two people's bedrooms on the ground floor and this presented a risk of infection. We also saw that staff did not always follow safe infection control practices. We raised this with management who told us that they would take immediate action to address these issues.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the skills and knowledge of the staff. A person said, "[Staff] are very good." A visitor said, "The staff here are really good."

We saw that staff received an induction when starting at the home. Staff told us they received regular supervision and records we saw confirmed this for most staff; however, nursing staff were not receiving supervision. We also saw that no appraisals had taken place. We raised this with management who told us that they would be taking action to address this issue.

The training matrix showed large gaps in staff completion of training including in the areas of fire safety, infection control, health and safety, dignity and respect, equality and diversity, first aid and safeguarding. We raised this with management who told us that training for all staff in all areas was being arranged as a matter of urgency.

Staff told us that they felt training could be improved. We were told that most training was workbook based and there was no additional assessment of people's knowledge after they had completed the workbooks. We observed that staff did not always competently support people during our visit in the areas of medicines, infection control and moving and handling.

This meant that not all staff were fully supported to maintain and improve their skills in order to effectively meet people's needs.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff asked permission before assisting people and gave them choices. Where people expressed a preference, such as not wanting to wear a clothing protector at a mealtime, staff respected them.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA.

We found mental capacity assessments were completed and best interest decisions documented when people were unable to make some decisions for themselves. For example, the use of bedrails or when people were receiving covert medicines. When people were being restricted, DoLS applications had been

made. Staff had an appropriate awareness of MCA and DoLS.

We saw staff responded well to people at times of high anxiety. We saw a person was quite anxious throughout most of our visit. A staff member distracted the person by talking with them using a gentle manner which had a positive impact on the person.

When people had distressed behaviours and behaviours others might find challenging, care plans provided information about the things which caused them distress or staff had identified as triggering the behaviour. They also included actions staff could take to calm the person and gain their cooperation. Some people were physically aggressive towards staff and their care plans stated that if all other measures failed or staff failed to gain the person's cooperation after several attempts, staff should use "safe holding techniques."

We asked staff how they cared for people when they were physically aggressive towards them and they said they would explain what they wanted to do and leave the person for a while if possible and try again later. They also said they would block the person by putting their (unclosed) hand on their arm to block them if they tried to hit out. When we asked what safe holding techniques they used, they described a similar action. We asked if they had received any specific training on safe holding or restraint and some staff told us they hadn't and would find it beneficial.

We looked at the care records for some people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. We saw that two DNACPR forms had not been fully completed. We raised this with the management who agreed to review all DNACPR forms. Staff told us that any errors in DNACPR forms would be raised with the relevant professional. Staff also said that reviews of DNACPR forms by external professionals did not always take place as promptly as would be liked by staff.

Feedback on the quality of the food was positive and people told us they had choices and their nutritional needs were met. One person said, "I like the food. It's very good and you can have as much as you like and whatever you like if they've got it." A visitor said, "There are two main options at lunchtime but I've seen people being offered four or five alternatives if they don't want it."

We observed the lunchtime meal in both dining rooms. Dining room tables were well laid with background music playing. People were offered choices and food looked appetising. People who were being assisted to eat were supported appropriately with staff members focussing their attention on that person and sitting at their level.

People told us that drinks provision was good and we observed people in bedrooms with a jug of water or squash provided, in addition to hot drinks and drinks with meals. We saw a number of people being given cups of tea when they requested them and snacks and biscuits were in plentiful supply all day. A person said, "You can always get a cup of tea or coffee. You only have to ask." People were weighed regularly and appropriate action taken if people lost a significant amount of weight.

People told us they were supported with their healthcare needs. A visitor said, "About two weeks ago [staff] were concerned about [my family member]'s breathing and called the paramedics."

Care records contained evidence of the involvement of a range of healthcare professionals when this was required. We saw evidence of the involvement of chiropodists, dieticians, the dementia outreach team and family doctors. People received responsive dental treatment when required and management told us that further work was taking place to ensure that people received preventative dental checks.

Some adaptations had been made to the design of the home to support people living with dementia, however more work was required. Bathrooms, toilets and communal areas were clearly identified. However, people's individual bedrooms were not easily identifiable and there was no directional signage to support people to move independently around the home.

People did not have access to a secure outside space. The garden areas were not safe or well maintained. We raised this with the provider who agreed to take immediate action to provide people with access to a safe outside area and told us that they would be generally improving the internal and external environment to better meet the needs of people who used the service in the future.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. A person said, "They're all lovely with us." Another person said, "They're all so nice to us." A visitor said, "What I really like is that there is really good staff continuity. [My family member] couldn't cope with different people all the time and that doesn't happen here. There are staff that I know were here ten years ago."

People told us that they felt comfortable with staff and that any concerns or requests were listened to. We saw a person telling a staff member all about where they had worked and the job that they had done and the staff member listened carefully and asked the person questions about what they were saying. Staff had a good knowledge of the people they cared for and their individual preferences. For example, staff clearly knew that one person would only sit in a red chair and they moved some chairs to make sure a red chair was available to the person.

Although people we spoke with were not familiar with a care plan, visitors told us that they felt involved in the care of their family member and were kept well informed. A visitor said, "They asked us lots of questions about what [my family member] likes and dislikes which reassures me that they respect their preferences." Another visitor said, "We were involved in the care plan and we have had a few meetings to review it." Staff told us people and their families were involved when care plans were developed and where people were not able to tell staff about their wishes and preferences, families were consulted about what the person would wish where appropriate.

Care plans indicated that people or their relatives were involved in the development of their care plans and in their review. Care records contained information regarding people's life history and their preferences. We saw where this information had been used to support people to access activities which met their needs. We also saw examples where relatives had been involved in the best interests decision-making process. This meant people could be assured that their views were taken into account during the care planning process to ensure that care met their personalised needs.

When people were unable to communicate verbally, care plans provided information about the gestures or body language people used to communicate with and how staff could better understand them. We observed staff clearly communicated with people and gave people sufficient time to respond to any questions.

Advocacy information was not available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. We raised this issue with management who took action to address this issue.

People told us that staff respected their privacy and dignity. A person said, "I can have my door open or shut and [staff] always knock." We observed staff knocking on bedroom doors and responding to people discreetly to protect their dignity. However, we noticed that some bathrooms could not be locked which meant a greater risk that people's privacy would not be protected. We informed management who told us

that they would address this issue.

We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

People told us that they were encouraged to be independent if they were able and to ask for help if required. A person said, "I can undress and get myself up when I'm ready." Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

A visitor said, "It's completely open visiting. I come most days and help with [my family member]'s lunch." Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Good

Is the service responsive?

Our findings

People told us that they felt their care was good and personalised to their needs. A person said, "I think I get everything I need." Another person said, "I get up about ten o'clock. That's what I like." A visitor said, "They understand [my family member] here and cater for their needs." Another visitor said, "They really do understand [my family member]. We know they are happy here."

People told us staff generally responded promptly when they rang their call bell. A person said, "[Staff] do come. I don't often have to wait long but sometimes I have to wait a long time for help and then they say they're sorry they've been a long time." We saw call bells were answered promptly and staff were responsive to people's requests for support. We saw a person was complaining of being uncomfortable in their wheelchair and a staff member quickly fetched a cushion and placed it behind them checking that they were now comfortable. We saw good interactions between staff and the people they cared for. These interactions indicated empathy for people and a caring approach by staff.

People told us that they had regular access to a bath or shower if they wished. A person said, "I have a bath when I want one." Another person said, "Most days I have a shower. It's up to me."

People did not raise any concerns about the activities that were provided. A person said, "I like to play the games. We do have some fun." A visitor said, "[My family member] has one to one [staff] and they play cards and dominoes with them."

We observed group activities and one to one activities took place during our inspection. The activities coordinator was energetic and interacted well with people who clearly enjoyed the activities. We saw that one person was supported to carry out an activity related to their previous employment occupation which showed that the activities coordinator had considered people's life histories when supporting them with activities that met their needs.

Records showed that some people were involved in group activities and others received one to one activities in their room. The activities coordinator explained the activities they offered and the plans they had for the future. We saw that few outside organisations had visited the home to provide activities and most people had not accessed activities outside of the home. Management told us that a budget would be made available for the activities coordinator in the near future which would allow a greater range of activities to be made available for people living in the home.

When people were admitted to the home, a preferences questionnaire was completed to identify their daily routine and preferences, including food likes and dislikes. We saw people had been involved in the development of their care plans and they provided a considerable amount of detail about their personal needs and preferences. They were up to date and reflective of people's current needs. Care plans were reviewed and evaluated monthly. Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs.

A person with epilepsy had frequent seizures and their care plan gave information for staff on action to be taken to keep the person safe and what to do if the seizure lasted more than five minutes. The care plan contained contact details for the community epilepsy specialist nurse and the Epilepsy Helpline.

No-one we spoke with could recall having had a need to raise a complaint and any minor issues had been quickly resolved. A person said, "I can speak up for myself and if anything wasn't right I'd soon tell them but I'm happy."

Recent complaints had been handled appropriately. Guidance on how to make a complaint was displayed in the home and in the guide for people who used the service. There was also an easy read version displayed to support people's understanding of this area.

There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them. A staff member said if a person raised a concern or complaint they would gather all the information they could and report it to the managers.

Requires Improvement

Is the service well-led?

Our findings

We saw that the service's management team had completed audits including in the areas of kitchen, medicines, domestic, care plans and health and safety. However, action plans were not always in place where required and these audits had not identified and addressed the issues we found at this inspection including training, supervision and appraisals.

CQC inspections in 2012, 2013 and 2014 identified breaches in regulations. The inspection in 2015 found that all regulations had been complied with, and the service was overall rated 'Good' but 'Effective' was rated as 'Requires Improvement'. At this inspection we have identified a breach of regulation and other areas as requiring improvement. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.

Visitors told us there were meetings and they had been sent a survey so they could provide their views on the quality of the service being provided. We saw meetings for people took place where comments and suggestions on the quality of the service were made. Comments were generally positive. We saw that the activities coordinator had introduced an activity following comments made in a meeting. However, we saw that people had raised the issue of garden access and prompt action had not been taken in response to this.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in the policy. The provider's values and philosophy of care were displayed and staff were observed to act in line with them during our inspection.

People told us the atmosphere of the home was good. A person said, "I love it here. We are a big happy family." A visitor said, "I think it's great. People seem really happy and it's spotlessly clean everywhere. It's a pleasure to visit." We found the home to be relaxed and friendly.

A staff member told us that the two managers currently covering the home were approachable and were easy to access. They said there was always a manager to call at the weekend if it was necessary. We were told there was a staff meeting approximately two weeks prior to the inspection and there was another staff meeting at the end of the week of our inspection. We saw that staff meetings took place and the management team had clearly set out their expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post; however, they were no longer working at the service and had submitted an application to cancel their registration for this service. The home was being covered by two managers from other homes owned by the provider. We spoke with one of the managers who told us that they felt well supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when

required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)