Ashness Care Limited

Ashness 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

This inspection took place on 23 July 2018 and was announced. The provider was given 48 hours' notice because the location provides a service for people who may be out during the day, we needed to be sure that someone would be in. At our last inspection on 30 December 2015 and 14 January 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

Ashness House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashness house provides care and support for up to five men with mental health needs. At the time of our inspection there were five men were using the service.

There was a registered manager at the service 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 and associated Regulations about how the service is run.

People told us they felt safe with staff and there were enough staff to meet their needs. Staff were trained in safeguarding and knew how to safeguard people against harm and abuse. People's risk assessments were completed, regularly reviewed and gave sufficient information to staff on how to provide safe care. Staff kept detailed records of people's accidents and incidents. Staff wore appropriate protection equipment to prevent the risk of spread of infection. Medicines were stored and administered safely however we have made a recommendation about the management of some medicines. The home environment was clean.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation protecting people who are unable to make decisions for themselves or whom the state has decided need to be deprived of their liberty in their best interest. We saw people had choices about their life. The service was well decorated and adapted to meet the needs of people using the service.

People told us that they were well treated and the staff were caring. We found that care records were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service. People had access to a wide variety of activities.

The service had not recorded exploring people's wishes for end of life care. We have made a recommendation about involving people in decisions about their end of life care.

The service had a complaints procedure in place and people knew how to make a complaint.

Staff told us the registered manager was supportive. The service had various effective quality assurance and monitoring mechanisms in place.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Ashness 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 23 July 2018 and was announced. The provider was given 48 hours' notice because the location provides a service for people who may be out during the day, we needed to be sure that someone would be in. The inspection team consisted of one inspector.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people with the service, and the local borough safeguarding adult's team. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, and two support workers. The provider had notified us the nominated individual was leaving the service. During the inspection we spoke to the outgoing nominated individual and the incoming nominated individual. We also spoke to four people who used the service. We looked at three care files which included care plans and risk assessments, two staff files which included supervision and recruitment records, quality assurance records, three medicine records, one finance record, training information, and policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "The staff take care of me." Another person told us, "I feel supported by staff. If I have a problem I don't have to deal with it myself and that gives me a feeling of safety."

Staff were aware of the various forms of abuse that could occur and the signs to identify them. They were aware of how to report any safeguarding concerns in line with the provider's safeguarding procedure. Staff told us they were confident that the registered manager would take appropriate actions to keep people safe. One staff member said, "First thing if I saw abuse is alert the manager. If they ignored it I would whistle blow to CQC." The registered manager understood their responsibilities in safeguarding people including investigating concerns, liaising with the local authority and notifying CQC.

Care records each contained a set of risk assessments, which were up to date, detailed and reviewed regularly. These assessments identified the risks that people faced and the support they needed to prevent or appropriately manage these risks. Risk assessments included the environment, finances, general presentation, physical health, daily living skills, harm to themselves and others, alcohol and other substances, and medicines. The risks to each person's safety and wellbeing were recorded in their individual risk assessments along with indicators of a mental health relapse where the person would need professional support. This included relevant contact details for health and social care professionals. Risk assessment processes were effective at keeping people safe from avoidable harm.

The service looked after money for one person who was unable to do this themselves. Financial records showed no discrepancies in the record keeping. The service kept accurate records of any money that was given to the person and kept receipts of items that were bought. Financial records were signed by a member of staff and the person receiving the money. Financial transactions were checked at daily handovers three times a day. Records confirmed this. This minimised the chances of financial abuse occurring.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded.

The service followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff had worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

People who used the service told us that they thought there were enough staff to support them safely. One person said, "I think there is enough staff." Another person told us, "There is enough staff here because there is only five people here so staff is enough." Staff told us they were able to provide the support people needed. One staff member told us, "There is definitely enough staff. Annual leave is covered by our other services." The provider had other services in the local area where staff could be used if cover was needed.

Our observations throughout the day showed sufficient staff were available to support people.

Medicines were stored securely in a locked cabinet in an office. We observed the office was locked when not in use. One person who needed medicines stored in a fridge had this available in their bedroom. This person also self-medicated. Records confirmed the service had completed a risk assessment on self-medication. The service also completed regular checks including the fridge temperature and whether this person had taken their medicine safely. This person told us, "I do my own medication because I want to be more independent. [Staff] check my medication regularly to see if I am taking [medicines] correctly." Medicines administration record sheets (MARS) were appropriately completed and signed by staff when people were given their medicines. Medicines records showed the amount held in stock tallied with the amounts recorded as being in stock. Medicine records for each person included the reason why the medicine was prescribed and the side-effects. Training records confirmed that all staff who administered or handled medicines for people who lived in the home had received appropriate training.

Records showed people had available "pro re nata" (PRN) medicines. However, the service did not have PRN medicines protocols in place which would describe the reason for taking the medicines and the maximum dosage. PRN medicines are those used as and when needed for specific situations. We spoke to the registered manager who told us even though PRN medicines were listed on the medicines administration record sheets (MARS), it was rarely given. Records confirmed this. The registered manager advised us he would consult with the GP and complete PRN protocols for people.

We recommend that the service consider current guidance on giving PRN medicines to people alongside their prescribed medication and take action to update their practice accordingly.

Equipment checks and servicing were regularly carried out. The service had completed all relevant health and safety checks including fridge/freezer temperature checks, fire system and equipment tests, emergency lighting, portable appliance testing, gas and electrical safety checks. Fire alarm systems were regularly maintained. Staff knew how to protect people in the event of fire as they had undertaken fire training and took part in practice fire drills. Records confirmed this. However, water temperature checks were not being recorded. We spoke to the registered manager who told us they would start immediately recording weekly checks.

The environment was clean and the service was free of malodour. Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control. One staff member told us, "I help [person] with a shower. We always wear gloves."

Good

Is the service effective?

Our findings

People told us staff were competent in their roles and had the skills to meet their needs. One person said, "If I have had any serious problems [staff] have always helped me."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. An assessment of needs was usually undertaken at a pace to suit the person, with opportunities to visit the service. The pre-admission assessment looked at personal and social history, reason for referral, psychiatric and forensic history, substance use, self-harm, current accommodation and social circumstances, personal hygiene, practical skills and finances, activities, physical health and relapse triggers. The registered manager told us there had been two new admissions since our last inspection.

Staff were trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. A staff member told us, "I've had every training. Rules and regulations are changing all the time so you have to keep up to date. Every year we have training." Staff we spoke with confirmed that they had received all the training they needed. The training matrix and staff files we looked at confirmed that staff had received training for their role which would ensure they could meet people's individual needs. This included training in topics such as safeguarding adults, medicines, first aid, fire safety, equality and diversity, health and safety, infection control, food safety, forensic mental health, understanding personality disorder, mental health awareness, managing challenging behaviour, mindfulness, stroke awareness, epilepsy awareness, nutrition, and Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

New staff joining the service completed the care certificate. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. Records confirmed this.

Staff told us they received monthly formal supervision and we saw records to confirm this. Topics included actions from previous supervision, updates on people who used the service, training, communication and key working. One staff member told us, "[Registered manager] will ask if I need any [training], and any problems. [Supervisions] are good." Records showed annual appraisals were being completed.

The kitchen was clean. People had their own cupboard for their food which was lockable. People confirmed they had their own key for their food cupboard. Each person had a fridge in their bedroom to store their food. One person said, "We have our own food cupboard which is locked." We saw records of fridge and freezer checks for the kitchen and people's bedrooms.

People told us that they had access to food and drinks throughout the day and were able to choose what they wanted to eat. Our observations confirmed this. People told us they cooked their own food. Staff told us most people cooked their own food. One person told us, "I cook myself. I am going [food] shopping today. Cooking yourself makes you more independent." Another person said, "[Staff] cook for me because of my disability. I get to pick my own food. [Staff] have cooked me [culturally specific] food." Staff encouraged

people to eat a healthy balanced diet. Some people had very specific dietary requirements. Records showed this was clearly documented in people's care plans and staff when asked knew people's dietary needs. One person said, "[Staff] make recommendations to eat more vegetables. I am trying to eat more broccoli."

People were supported to maintain good health and to access healthcare services when required. Records showed people visited a range of healthcare professionals such as GPs, opticians, dieticians, chiropodists, dentists, and psychiatrists. One person told us, "[Staff] call the doctor for me whenever I need an appointment." Another person said, "I see my GP and social worker every month and my care coordinator every two weeks." This showed the service was seeking to meet people's health care needs.

The premises, décor and furnishings were maintained to a good standard. They provided people with a clean, tidy and comfortable home. During the inspection, the service was in the process of redecorating the premises which included painting and new carpets. People were consulted in the redecorating and records confirmed this. There was a secure accessible garden for people's use. People's bedrooms were personalised.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. At the time of our inspection the registered manager told us there were no DoLS authorisations in place and no applications had been submitted for people currently using the service.

People told us they could go out whenever they wanted though two people needed support to do so. Staff told us these two people had capacity to make decisions for themselves however they felt safe when a staff member supported them in the community. One person said, "I'm not restricted but most times I need [staff's] help. Outside can be daunting." Another person told us, "You have lots of freedom. You can go out shopping. Here you can just go out."

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members asked their consent before helping them. This consent was recorded in people's care files. One person told us, "[Staff] ask you this and that like wanting to help me. They ask politely." Another person said, "[Staff] ask to assist to me as I am disabled."

Our observations showed that staff asked people about their individual choices and were responsive to that choice. One person said, "I have choices." Another person told us, "I can make a lot of choices for myself and I like it." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "I would say [staff] are [caring]." Another person told us, "[Staff] are very good and hands on. Anything I need I just tell them." A third person said, "I like the care home."

The philosophy of the service was to encourage people to become as independent as possible. One person told us, "I bought my laptop and knew nothing about it. [Staff] helped me and now I know a lot." Another person said, "[Staff] done a lot for my independence. They encourage me to shower independently." The same person said, "The best thing is I am independent." A third person told us, "[Staff] encourage me to be positive like doing activities and cleaning my room." Staff encouraged people to do their own shopping and cooking as far as they were able. Where people were not able to cook proper meals or keep their room clean, staff helped them or did it for them, depending on the person's individual needs. One staff member said, "Everyone is an individual and has their own capabilities. With [person] we helped him cook and now he cooks on his own."

Staff spoke in a caring way about people they supported and told us that they enjoyed working at the service. One staff member said, "I like to think [people who used the service] get on with me. I think I have a good relationship with them." Another staff member told us, "I have a good relationship with the residents." Throughout the day we saw staff engaging with people in conversations with a genuine interest in their well-being and day to day life.

People told us they had regular key working sessions. One person said, "I think it is helpful to have key worker meetings." Another person told us, "[My] key worker is [staff member]. We discuss everything like my development. Concentrate on things I'm struggling with." Staff knew the needs and preferences of the people they were caring for and supporting. Each person using the service had an assigned key worker. A keyworker is a staff member who is responsible for overseeing the care a person received and liaised with professionals or representatives involved in the person's life. One staff member said about key working, "Gives you a proper focus on the person so they reach their full potential." Records confirmed key working sessions were being regularly completed.

People were actively involved in making decisions about the care and support provided. Care plans were reviewed regularly with input from people. Records confirmed this. One person told us, "Every month we talk about the care plan. We discuss whatever my needs might be."

People's privacy and dignity was respected. One person said, "[Staff] knock on my door. [Staff] tell me who is going to be [staff member on duty]. They pass on my details to them so everything is coordinated." The same person told us, "[Staff] allow me to change in private and knock on my door if I need them." Staff we spoke with gave examples of how they respected people's privacy. One staff member told us, "It's my place of work but it's someone's home. I would knock on [person's] door. If they don't want to do something that's entirely up to them. We can't push anything onto them, only encourage them."

Good

Is the service responsive?

Our findings

People told us the service was responsive to people's needs. One person told us, "If you need help you ask staff. They have sorted out a lot of problems." Another person said." [Staff] make sure anything I need I get."

Care plans were written in a way that people understood and were signed by the people who used the service. One person said, "I have a care plan. I can make comments on the [care plan] and they are taken seriously." This showed us that people agreed to the support and care they would receive. Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's individual needs. The care plans covered mental health, physical health, nutrition, daily living skills and levels of independence, social networks, activities, training and employment, relationships, and substance use. The care plans were mostly person centred. For example, one care plan stated, "I'm doing my own cooking on my own, my shopping on my own and I'm very independent." People were also involved regularly with the review of their care plan. Records confirmed this.

People's individual diverse needs both cultural and spiritual were being met. One person told us, "I don't get disturbed when I pray. [Staff] do respect [pray time in bedroom]." Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We would work to accommodate [person's] needs. If someone was LGBT and wanted to be supported to an LGBT event we would take [them] with staff." A staff member told us, "Everyone is an individual. I respect their religion and sexuality. We are all human beings."

People had opportunities to be involved in hobbies and interests of their choice. People who used the service had the capacity to make decisions about which activities they would participate in. From our observations and what people told us people liked to spend time in their bedroom, communal areas of the service and in the community. People were supported to engage in activities outside the home to ensure they were part of the local community. One person said, "I play chess, play pool and go to college. I have a good social network. I do lots of things." A second person told us, "We are going tomorrow to the seaside." A third person said, "I do enough. I've got my [electronic tablet] and I read. Other residents play games and dominoes and I join in."

The service held a monthly house meeting where people could share and receive information. Records confirmed this. Topics discussed included activities, advocacy services, key working, house maintenance and room cleaning. One person said, "We do have residents' meeting. We talk about activities, going to the seaside and bowling." Another person told us, "Talk about the home, our needs and events coming up. Sometimes [staff] discuss care plans."

There was a complaint process available. The complaints process was available in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. The complaints policy had a clear procedure to follow should a

concern be raised. One person told us, "Never had a problem. If not happy I would tell staff." Another person said, "If not happy with something I would speak to the manager."

The registered manager told us there had been no complaints since the last inspection. However, we spoke to one person who told us they made a verbal complaint six months ago. The person said, "I made a complaint about a member of staff. It was resolved." We spoke to the registered manager about why the complaint was not recorded. The registered manager advised us verbal complaints were resolved, if possible immediately however were not always recorded. The registered manager told us all complaints will now be recorded.

At the time of our inspection the service did not have any people receiving end of life care. The service had an end of life policy which was appropriate for people who used the service. One staff member said, "[I would] sit down with [person] and speak about any worries and concerns. If religious I would speak to a priest." Records showed that end of life wishes were not recorded during the initial assessment and care planning stages. This meant there was a risk people did not have a chance to explore their end of life wishes and where they would like to spend the last stages of their life.

We recommend that the service seek advice and guidance from a reputable source, about the end of life care for people.

Good

Is the service well-led?

Our findings

People who used the service told us they liked the registered manager and they thought the service was well managed. One person said, "[Registered manager] is a good guy. He is a good manager. When you ask for something he helps you." Another person told us, "[Registered manager] is very good. Whenever I've had a serious problem he has been there for me and calmed me down. Really helped me."

There was a registered manager in post. They were aware of their responsibilities as registered manager and of the need to notify CQC about reportable incidents. They had current policies and procedures in place to run the service.

Staff spoke positively about the registered manager. One staff member told us, "I get a lot of support from the management staff. [Registered manager] is very good." A second staff member said, "[Registered manager] is very supportive. He has helped me a great deal. I can always ask a question and have a chat."

Staff told us that the service had monthly staff meetings where they were able to raise issues of importantance to them. Records confirmed this. Minutes from these meetings included topics and updates on people who used the service, activities, key working, infection control, health and safety, and house maintenance issues. One staff member told us, "We have monthly staff meetings to discuss any issues and residents."

The registered manager told us that various quality assurance and monitoring systems were in place. Records showed the registered manager did weekly checks on medicines, people's finances, health and safety, and accidents and incidents. The service also employed an external person who did a regular audit on the service. The audit included checking staff files which included DBS checks, training, appraisals and supervision. The audit also looked at people's care plans, risk assessments and health profiles. This meant people could be confident the quality of the service was being assessed and monitored so that improvements could be made where required.

The service also conducted an annual review of the service. The last annual review was completed 8 November 2017. The annual review looked at topics such as equality and diversity, barriers to improvement, lifestyle, medicines, complaints, environment, recruitment, and training for the service. The review looked at where the service was meeting the needs of the service and evidence to show this, where they could do better, and how they have improved since the previous annual review. For example, the annual review had highlighted the lounge and kitchen area needed to be refurbished and how they planned to address this. During the inspection we saw work had begun to address this.

There were systems in place to monitor people's satisfaction with the service. People who used the service were given an annual survey to complete. The last survey completed for people was November 2017. The survey covered topics such as trust and confidence in staff, respect and dignity, cleanliness, issues being addressed, and feeling safe. All five people who used the service returned the survey and overall the results were positive about the service.

The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us they worked with local mental health and clinical teams, social services and local colleges and voluntary services.