Ashmere Care Group

West Hallam Care Home

Inspection report

8 Newdigate Street, West Hallam, Derbyshire DE7 6GZ
Tel: 0115 944 0329
www.ashmere.co.uk

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Ratings

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

Overall summary

This was an unannounced inspection which took place on 30 October and 4 November 2015. We had previously carried out an inspection on 26 February 2014 when we found that the service had breached the regulation relating to the management of medicines. On this inspection we found that the provider had taken action in relation to this.

West Hallam Care Home is a 31 bed residential home. It has two parts: the main home provides residential care for 19 people, and the extra care unit provides specialist care for 12 people with dementia. There were 24 people living in the service at the time of our inspection. 12 people were living in the extra care unit and 12 people were in the residential area of the home.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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

Summary of findings

service is run. There was a newly appointed manager in post at the time of our inspection, and they were in the process of applying to become a registered manager with CQC. The previous registered manager left on 8 May 2015.

We found a breach of regulation 12 and a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People told us they felt safely cared for. Staff were trained and knew how to recognise people at risk of harm. They knew how to report concerns.

There were safe recruitment procedures in place. The provider carried out checks to ensure that suitable people were recruited. Staff undertook a probationary period before being assessed as competent to provide care. The provider had policies and procedures in place if staff did not meet the standards expected of them.

People and their relatives felt there were enough staff employed to provide care. Staff held mixed views on this, and the evidence that we saw showed that there were times when there was a risk of people not receiving the support they needed due to the way staff were deployed.

Medicines were stored, administered and disposed of safely and in accordance with professional guidance. We found that staff did not always keep records relating to "as required" medicines. Staff received training in the safe administration of records.

People were supported by staff who received training and supervision to ensure that they had the skills the provider felt necessary for their role. The interaction we saw between people and staff demonstrated that people's independence was promoted.

Staff obtained consent from people before providing support. Where they were not able to do this, not all staff understood the requirements of the Mental Capacity Act. This meant that there was a risk that best interest decisions did not meet with legislative requirements.

Staff knew people well and understood how to provide care that was person centred. People were involved in planning their care.

People were supported to have a well-balanced diet. They had regular drinks and snacks, and diets to meet their health needs. Staff provided alternative meal choices and people were involved in discussions about the menu.

Staff communicated well with people and provided care in a kind and compassionate manner.

A wide range of activities were on offer, and families and friends were welcome in the home. This meant that people could continue with their hobbies and interests, remain active and maintain relationships that were important to them.

The provider sought feedback about the service from people, their relatives, visitors and staff. There were a variety of ways people could make their views known. The provider demonstrated how they listened to people and responded to improve the service, but the recording of this was variable.

There were systems in place to monitor and review all aspects of the service. However, these had not always been carried out. This meant identifying areas of good practice and areas for improvement was inconsistent.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People did not always have risk assessments and care plans in place to minimise the risk of harm.

Medicines were stored and disposed of safely and in accordance with guidance. However, medicines were not always managed in a way that reduced the risk of harm.

Staff were recruited safely and received training to enable them to provide care.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people's individual care needs.

People were provided with a choice of suitable and nutritious food and drinks.

The manager was aware of their responsibilities with regards to the Deprivation of Liberty Safeguards to that people's care was least restrictive and lawful. Staff had variable knowledge of their duties and responsibilities under the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the staff team.

People were supported by staff who understood how to care for them in a respectful manner that upheld their dignity.

Is the service responsive?

Good

The service was responsive.

Opportunities were available regularly for people to take part in activities.

The provider had systems in place to listen to views and respond to concerns and suggestions for improvement.

Is the service well-led?

Requires improvement

The service was not always well led.

The provider's quality management system was not routinely used and did not highlight areas of concern in a timely manner.

The new manager had put together action plans to improve the quality of care and we could see evidence of action being taken.

West Hallam Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 October and 4 November 2015 and was unannounced. The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people.

Before our inspection we reviewed the information we held about the service including notifications the provider sent us. We spoke with the local authority commissioning team and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received.

We asked the service to complete and provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with eleven people who used the service and two relatives. We also spoke with the provider's area manager, dementia specialist, the service manager, seven staff and one visiting health professional. We accessed a range of records relating to how the service was managed. These included five people's care records, 2 staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI) to capture the experiences of people who may not be able to communicate their views.

Requires improvement

Is the service safe?

Our findings

One professional we spoke with expressed concern about needing to repeatedly raise issues with staff, particularly in relation to people's skin care. For example, they had recommended that one person sit on a pressure relieving cushion to reduce the risk of pressure sores. They said that there had been subsequent instances where the person was not using the cushion. We looked at the care plans and risk assessments for this person. The records for the person showed that they were at risk of pressure sore and skin breakdown, and "needs checking regularly." The care plan did not give any information about how often checks should happen or what action staff should take. There was no information about what sort of seating or mattress the person required to reduce the risk of skin breakdown. We spoke with the manager about the person's skin care. The person liked to move about and sit on different chairs. Staff had arranged for more cushions to be provided and were planning to improve monitoring of this person's skin care. They acknowledged that the person's care records did not have enough detail to ensure that staff could minimise the risk of skin breakdown. This showed us that people were at risk of skin breakdown, and there was a risk that there was not enough information for staff to be able to keep them safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One professional we spoke with identified another person who spent prolonged periods of time in their wheelchair. We looked at the care plans and risk assessments for this person. We looked at the records relating to the person's skin care, which identified them as being at high risk of skin breakdown. They had an up to date risk assessment and care plan stating what pressure care they needed. Staff recorded how often the person was supported to reposition their seating. There was an assessment which stated that the person had capacity to make their own decisions about their skin care, and that they understood the risks.

People did not always have risk assessments and support plans in place to minimise the risk of harm. We saw records that identified two people as having periods of distress and agitation that could place them or others at risk of harm. However, we did see staff interacting with people in a positive and calming way during our inspection. There was little information recorded about what might trigger behaviour and how staff should support people at these times. One of the people had no risk assessment relating to behaviours which could harm the person or others.

Medicines were not always managed in a way that reduced the risk of harm to people. People who had medication "as required" did not have protocols for this. We spoke with staff and the manager about this. The manager had already identified this as an issue, and confirmed that this was currently being addressed. Records confirmed that this was the case. However, this meant that prior to our inspection, staff did not have clear guidance for people's "as required medication." This meant that people were at risk of not having their medicine as prescribed.

Staff told us and we saw that medicines were stored and disposed of safely and in accordance with guidance. People received their medicines from staff who had received training in safe medicines administration and had competency tests done by a manager who worked for the provider. The provider's notification to CQC demonstrated that appropriate action was taken where staff competencies were not at a level the provider required. One staff member said they felt, "competent and knowledgeable" about the management of medicines. Staff were knowledgeable about current guidance and advice regarding medicines and knew when to seek advice.

The medicine administration records we looked at were complete and did not have any gaps in recording. However, staff were using a code on the records which was not defined. Staff told us that they thought this was used to indicate that a person was asleep. However, the meaning of the code was not clearly documented. This meant that there was a risk that staff were not consistently recording why people did not have their medication at the time prescribed.

People and their relatives told us that they felt there were enough staff available. One person told us, "They always come to help me when I ask," and another commented, "Generally I feel there are enough staff on duty." A visiting professional did not feel that there were sufficient staff available to meet people's needs. They described this as both an issue with staff numbers on shift and also deployment of staff. They said that this had been better since the new manager started, but remained a concern.

Requires improvement

Is the service safe?

Staff had mixed views about staffing levels. Two staff felt there were usually enough staff available, but a third staff member commented that there were not enough staff and that this had an impact on care provided in the mornings. They told us, "Residents are safe, but routines get pushed back." Another staff member said, "There's only one night staff on the residential side – this is insufficient." They said that they had raised this as a concern previously with the provider. We saw that people received support in a timely manner during our inspection. We saw records of staff meetings which showed us that concerns about staff shortages had previously been raised, for example, in February and March 2015. Staff described the impact that staffing levels had on people. For example, one staff member described a person needing one to one support and another person who needed the assistance of two staff to transfer seats in the extra care unit. They told us that there were only two staff on the extra care unit during the day and this was not enough to be able to meet both those people's needs at times, as two staff were required to use the hoist safely. We looked at both people's care records, which confirmed that they required a high level of support and monitoring from staff.

The provider used a dependency assessment tool to help them establish how many staff were needed. We looked at these and also at the staff numbers at different times of the day and night. This showed us that there were enough staff available to meet people's needs according to the assessment of people's needs. The manager told us that there were times when one staff from the extra care unit would go through to the residential part of the home if they were needed (for example, if there was an emergency). However, this would leave only one staff available on the extra care unit, and we saw that one person needed two staff to meet their needs at times. This left people at risk of not receiving the support they needed due to the way staff were deployed.

People and their relatives told us that they felt safe living at the service. One person told us, "I do feel fairly safe here," and another person commented, "I know what safe means and it's as safe as anywhere here." Staff understood how to recognise potential abuse and how to raise concerns. They were confident to do this and felt they would be supported by the manager. One staff member spoke about raising concerns and said this had been dealt with properly by the provider. Records showed us that appropriate referrals were made to the local authority in relation to concerns or allegations of abuse. Staff received training in safeguarding and were able to describe what action they would take to raise concerns with the provider and the local authority. Not all staff had easy access to up to date information about recognising and reporting concerns. The provider's policy referred to out of date guidance from the local authority. We spoke with the manager about this and the guidance was updated during our inspection. People were therefore protected against the risk of abuse.

The provider had plans in place to support people in the event of an emergency affecting the whole service, For example, on the second day of our inspection, the manager and provider were arranging the replacement of a broken boiler. We identified that this would be done in a timely manner, and that there were contingency plans in place if the second boiler failed.

Staff told us the provider undertook pre-employment checks, including references and disclosure and barring service (DBS) checks. Recruitment procedures included checking references and carrying out disclosure and barring checks to ensure that prospective employees were suitable to work with people living at the home. All staff had a probationary period before being employed permanently and undertook an induction period of training the provider felt essential. This meant that people and their relatives could be reassured that staff were of good character and remained fit to carry out their work.

Good

Is the service effective?

Our findings

All the staff we spoke with felt that they received enough training to have the skills and knowledge to support people effectively. Staff also felt that they received supervision regularly and this helped them improve their care skills. The records we looked at showed that staff undertook training and competency assessment to enable them to meet people's needs safely. We saw evidence that the provider clearly set out what they expected from staff if there were issues with their skills. This was set out in people's job descriptions and contracts. The provider had policies that stated what support staff would be given, and what action the provider could take if care was being given in a way that did not meet their standards.

Staff were knowledgeable about the people who lived at the service. They were able to give specific examples of what different people's care needs were and what sort of support was offered. The records we looked at confirmed this. For example, one staff member described how they would support a person who became agitated. We saw the person being supported in this way during our inspection, and saw that staff's actions had a calming effect on them. The person was then able to take part in an activity and we could see that they enjoyed this as they were smiling and laughing.

The provider employed a member of staff who was a dementia specialist. They were involved in supporting and training staff who worked in the extra care unit. Staff in this unit received additional training in supporting people with dementia. We saw evidence that told us the provider was developing additional training and assessment for staff who supported people with dementia.

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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that capacity assessments had been carried out where this was required and that people's views and opinions were taken into account in best interest decisions. This showed that people either made their own decisions or were involved in decision making, where they were assessed as lacking the capacity to make the decision for themselves. We saw that staff sought people's consent before offering care, and spoke with people to make sure they understood what was happening.

We asked staff to tell us what they understood about the MCA and DoLS. Staff and the manager told us that they had attended training on the MCA and DoLS and training records confirmed this. We saw that the provider's policy did not contain up to date information about the scope of DoLS applications. However, the manager demonstrated a good understanding of this. Staff knowledge on how they should support people who were unable to make their own decisions was variable. This meant that there was a risk that staff did not always understand or apply the principles of the MCA.

The provider had made DoLS applications for 15 people, but no authorisations had been granted at the time of our inspection. Records showed when the applications had been made and that the manager had informed the local authority of any people whose applications were a priority.

People spoke very positively about the quality and quantity of the food and drinks available. They told us that they were given choices and that staff would offer alternatives if they did not like what was on the menu. Relatives told us that staff knew people's food preferences and supported them to eat well.

People were involved in menu planning and staff told us that they regularly sought people's views about the quality of meals. The provider had monthly "bistro" evening meals with different themes. Records showed that relatives, friends and staff attended these, and we saw that feedback from relatives and friends was positive.

Staff were knowledgeable about people's needs in relation to food and drink. Staff knew who needed encouragement to eat and drink, and what people's dietary requirements and preferences were, for example, two people needed soft

Good

Is the service effective?

food diets. The provider had adapted cutlery and plate guards for people who needed these to enable them to eat more independently. We saw that these were being used by people at meal times.

We saw at lunchtime that people were free to choose where they wished to have their meal, and that everyone was offered drinks regularly. We saw people being supported and regularly encouraged to eat by staff. People who needed assistance with cutting up food were offered this. One person requested a different meal from the planned menu, and staff offered a range of alternative options. This demonstrated that people were supported to have sufficient food and drinks throughout the day.

People and their relatives told us that they felt staff supported them when they needed healthcare services. One person told us, "I needed new glasses and they sent someone in to check my eyes and get me some, which are okay." A relative said, "The staff were very good at noticing [person] wasn't very well and got them to hospital very quickly".

Staff we spoke with were knowledgeable about people's health conditions and how to support them. The records we looked at confirmed this, and showed us that people were supported to access health and social care services in a timely manner.

Good

Is the service caring?

Our findings

People and their relatives felt that staff provided care that was kind and compassionate. One person said, “I do love living here.” A relative told us, “The staff are so kind and caring, thoughtful and dedicated.” A health professional described staff as kind and caring.

Staff responded to people in a caring manner throughout our inspection. For example, we saw a member of staff talking with people about what films they liked to watch, and planning a film night with them. The activities coordinator was present on both days of our inspection. They promoted conversations with people about their hobbies and interests. We saw people being supported to take part in a group activity in the afternoon that was fun and enjoyable. People were also supported by the activities coordinator in individual activities, for example, having a manicure, reading a paper and reminiscence conversations.

Staff were knowledgeable about how to support people to express their views and preferences about their care. Staff knew how to give information to people in a way that encouraged them to make their own decisions. For example, one person had clear information in their records about when and how they wished to be supported to have their medicines. We heard staff giving people clear information about care being offered, and giving people time to respond. People were involved in discussions about their care and the records we viewed reflected this.

We saw that people were encouraged to have their bedrooms decorated to their taste, and people had personalised their rooms.

Staff we spoke with were not familiar with the support that independent advocacy could provide to people. However, there was information available around the building about local advocacy services. This meant that there was a risk that people could not access advocacy services unless they understood what this was and were able to do this for themselves.

Staff spoke with people in respectful and positive ways, and asked their permission when offering to support them. For example, we saw staff prompt and support people to use the toilet in a way that was discreet and sensitive.

A health professional said that they thought staff treated people with respect and dignity when providing care. Staff demonstrated understanding and knowledge of how to support people in ways that promoted their privacy and dignity. We saw staff offering people the option of having a fabric apron at lunchtime to protect their clothing from food spills. This was done in a tactful way and staff were clear that this was an option for people if they wished. We also saw that staff were mindful of confidentiality when discussing care with people.

Good

Is the service responsive?

Our findings

People were involved in planning their own care and were supported to maintain their hobbies and interests. People told us that they were able to make choices about their day to day routines and activities. For example, people's preferences about when they got up and went to bed were respected.

The provider employed a full time activity co-ordinator, and people spoke positively about the different activities that were available. One person said, "I do like the musical people we have and when they come in its really nice," and another person commented, "We get visits from people with animals and music acts, so I quite enjoy living here because of that." We saw records that confirmed that the provider had a range of activities on offer throughout the week, including craft and music activities and trips out. We also saw different people taking part in one to one activities that they had chosen.

Staff knew what people's likes and preferences were, and we saw that these were recorded in people's care plans. They told us that information about people's hobbies and activities was reviewed monthly, and records confirmed this. This enabled staff to offer people activities and opportunities that were more personal to them. Staff also knew what people's individual care needs were and how they liked to be supported. For example, one person had a visual impairment and needed staff to clearly describe what support they were offering. We saw this person being supported at lunch time, when staff were describing what the food was and where it was on their plate. This enabled the person to eat more independently.

People told us that they knew how to raise concerns and make a complaint. They felt confident to do this. For example, one person told us, "I would know how to complain if I had to and I'd either talk to the manager or ring the top boss, but I've never seen a need to in the time I've been here." Relatives also understood how to make complaints, including how to raise concerns with the local authority and CQC if necessary. There was information available in the home about the provider's complaints policy. The provider's records relating to complaints and how these were managed did not consistently demonstrate what action was taken as the result of a complaint.

The provider had a variety of ways to seek feedback about the service from people and their relatives. We saw that a variety of questionnaires had been sent to people and their relatives, for example, there were regular surveys asking people's views about food, activities and entertainment. One of the suggestions made by people was to have a regular film evening. People told us that they liked to watch a variety of films and staff confirmed that they had supported people to do this. The provider undertook a relatives and visitor survey and the results included highlighting any improvements made as a result of feedback. The provider held meetings regularly for people to talk about the care they received and to make suggestions about what changes they wished to see.

Requires improvement

Is the service well-led?

Our findings

The provider had a system of quality management in place which was designed to identify areas for improvement in the service. The evidence that we saw demonstrated that this system did not always pick up issues or concerns about people's care. For example, the provider's audits had not picked that not all people had risk assessments and care plans in place where there was an identified need for this.

The quality management system had a monthly manager's audit, but the last audit was undertaken on 7 November 2014. This audit was comprehensive and covered all aspects of care, for example, ensuring care plans were up to date, environmental checks, accident and incident analysis and listening to people's views about their care. There was evidence that these checks had been carried out since the last manager's audit, but there was no overall system being used to monitor quality of care and results of action taken. For example, the only monthly audit of people's care records that we could find was dated 3 September 2015. There was no evidence that the monthly checks had been happening in any other month. We also found that the last six-monthly night time audit was carried out on 23 October 2014. We spoke with the manager about this, and saw evidence that they had now taken actions to ensure that these audits would take place. However, this meant that the provider did not have a robust or effective management system in place to look at people's overall care experience. There was a risk that poor practice could not be identified and remedied quickly.

This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives felt that staff and the manager were approachable and open to listening to their suggestions or concerns. One relative said, "I do feel the staff and new manager are very approachable and I can bring up any issue with them." Another relative commented, "I can approach them about anything and even the odd minor complaint is dealt with at once." This meant that people and their relatives felt able to raise suggestions and concerns, and these would be acted on. Staff also felt able to raise concerns or make suggestions about improving the service.

Staff knew what the vision and values of the provider were and what this meant for people's care. Staff stated; "Dignity. We're here for the residents. Good activities. Individual time with residents." Staff also felt supported by the service's new manager, with one staff member saying, "[The manager] has installed a sense of security. I respect [the manager]." Other staff commented, "[The manager] is easy to talk to and makes time for you," and, "[The manager] has put in better rules. I feel settled now."

The manager was in the process of applying to become the registered manager. They understood their responsibilities, for example, when and why they had to make statutory notifications to CQC. We could see evidence that showed us they had begun to make improvements to the service.

One health professional we spoke with said that they historically had issues with the care the home provided, and observed that there had been a number of managers. They said they had recently spoken with the new manager, and felt confident that they would be able to improve the care where this needed to happen.

The new manager had only been in post for two weeks at the time of our inspection. However, they had identified a number of issues relating to care provision which our inspection highlighted. The manager already had an action plan in place to address concerns raised during our inspection. For example, all staff who had responsibility for medicines were scheduled to have additional training. The manager had also started audits of individual staff competency to identify what support staff needed to be able to manage medicines safely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment must be provided in a safe way for people where the provider does all that is reasonably practicable to mitigate risks Regulation 12 (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have effectively operated systems or processes in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a).