HC-One Limited

Ashgrove 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?	Good
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on the 18 and 19 November 2015 and was unannounced. At our last inspection on the 4 February 2014 the provider was compliant with the regulations inspected.

Ashgrove Nursing Home is registered to provide accommodation and support for 57 older adults who may have dementia. On the day of our inspection there were 46 people living at the home. There were 31 people living in the nursing unit with 8 beds allocated as a short stay for people leaving hospital managed through the Clinical Commissioning Group (CCG) and 15 people living in the residential dementia unit. There was a registered manager in post. 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.

Summary of findings

People told us they felt safe. The provider had the appropriate safeguarding procedures in place so staff knew how to keep people safe.

People told us there was not always enough staff. We found that there was a number of vacant job positions which led to there not always being enough staff.

The provider did not ensure that an appropriate running balance of medicines were kept so they could monitor that people were receiving the correct amount of medication.

Staff received support and training to ensure they had the skills and knowledge to support people appropriately.

The provider had taken the appropriate action to ensure they met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People told us that staff were kind and compassionate towards them, but our observations did not always reflect this throughout the home.

People were able to make decisions about the support they received from staff.

People's dignity and privacy was not always respected.

Activities were not consistently made available to people by staff and they did not all know what people's preferences, likes and dislikes were.

People told us that if they had a complaint they would speak to the staff or registered manager.

We found that the quality assurance system were not effective in identifying concerns within the service where improvements could be made.

The provider ensured systems were in place so people were able to share their views on the service. An action plan was being used to identify what the provider did about the views people shared.

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 always safe.

People, relatives and staff told us there was not always enough staff. We found that there was a number of vacant posts which led to there not being enough staff.

People received their medicines as prescribed. The appropriate running balance of the medicines left after administration was not being carried out to ensure people were receiving the correct amount of medication.

The provider had a suitable recruitment process in place to ensure people were supported by appropriate staff.

Is the service effective?

Good 

The service was effective.

Staff were able to access support when needed through regularly supervision, staff training and appraisals.

The provider ensured people's human rights were not being restricted in line with the Mental Capacity Act (2005).

People were able to make choices about the meals and drinks they had to ensure they were not malnourished.

Is the service caring?

Requires improvement 

The service was not always caring.

People told us that the staff were kind and compassionate. However, our observations showed at times this was not consistent.

People made decisions about the support they received.

People's dignity and privacy was not always respected.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People we spoke with on the nursing unit told us there was not always enough activities. We saw that people's preferences influenced planned activities available on the residential unit.

People knew how to complain and told us they would complain to the manager.

Is the service well-led?

Requires improvement 

The service was not always well led.

Summary of findings

We found that quality assurance audits being carried out were not effectively identifying concerns within the service.

People were able to share their views on the service in a number of ways to allow the provider to make improvements as necessary.

Ashgrove 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.

Our inspection took place over two days 18 and 19 November 2015 and was unannounced. The inspection was conducted by one inspector 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 asked the provider to complete a Provider Information Return (PIR), which they did not return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We spoke with 10 people who were able to share their views with us, five relatives, a visiting health professional, eight members of staff including a nurse, care assistants, senior care staff, kitchen staff and an activity coordinator. We also spoke to the registered manager. We spoke with another health care professional on the telephone. We looked at the care records for four people, the recruitment and training records for four members of staff and records used for the management of the service; for example, staff duty rosters, accident records and records used for auditing the quality of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us there was not always enough staff. One person said, "There are times when more staff are needed". A relative we spoke with said, "Sometimes they get short staffed, I've heard them [staff] say so". Another relative said, "There's enough staff generally". Staff we spoke with told us there wasn't enough staff. One member of staff told us that people who were in the short stay unit went into other people's bedrooms because there wasn't enough staff to manage the situation. We saw a number of people had been left in the sling that was used to hoist them and our observations were that staff saw nothing wrong with this practise. This practice was staff trying to save time so they did not have to put the sling on the person each time they used the hoist, but also people could develop sore skin sitting in the sling for long periods. We saw staff walking in and out of the lounge with no attempt made to stop and talk with people and as a result people were left to sit for long periods of time with no interaction. On one occasion someone was sliding down in their chair and staff were not around to support the person. A relative told us, "They could be a bit more observant. Sometimes there's no staff in the lounge to notice if a person collapses". Staff we spoke with told us they had requested more staff to support people but nothing had been done. We found that the amount of staff working on the nursing unit was less than the staffing rota suggested due to a reduction in the amount of people on the unit. A staff dependency tool was being used to determine the appropriate staffing levels. We saw evidence that there were a number of vacancies that had not yet been appointed to within the home, which impacted on there not being enough staff. The registered manager acknowledged it was an oversight on their part not to have had enough staff on shift and that people should not have been left to sit in their slings. The manager also confirmed they were currently interviewing and hoped to be in a position to appoint to a number of posts. On the second day of our inspection we saw that the staff on shift reflected what was on the rota and people were no longer sitting in hoist slings.

During the lunch time we saw that not all people on the residential unit had the support they needed to eat and drink due to staff availability. We saw a couple of people struggling to eat their meal, one person had not been given any cutlery. We saw that staff were rushing about trying to support people in the dining room and in their bedrooms. The registered manager acknowledged there were staffing concerns during meal times on the residential unit and this was due to the unit being decorated and two lounges being used during meal times as well as people being supported in their bedrooms. This would be rectified once the decoration was completed.

The staff we spoke with all told us they were required to complete a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. This check was carried out to ensure that staff were able to work with vulnerable people. The provider's recruitment process also included references being sought. Staff confirmed they were able to shadow more experienced staff as part of an induction process and their experiences, skills and knowledge were checked before an appointment was made. We found that where nursing staff were being employed or used via an agency the appropriate checks were taking place to ensure these staff were appropriately qualified and registered.

People we spoke with told us their medicines were usually made available to them how they wanted and on time. A person told us, "If not, I would tell a member of staff and they'd sort it out". Another person said, "Not always on time". A relative said, "She gets her regular medicines as it should be". Staff we spoke with told us they were not able to give medicines until they had completed the appropriate training. They also told us that their competency to administer medicines was being checked and we saw evidence to confirm this.

The provider had a medicines procedure in place to support and guide staff when administering medicines. However, we found that staff did not always follow the procedure. We saw that where people's medicines were administered via a Percutaneous Endoscopic Gastrostomy (PEG) feed there were no proper processes available on people's records to guide staff as to how this should be managed. A PEG is a way of introducing food, fluids and medicines directly into the stomach. We spoke to one member of staff who was able to explain what they did but there was no evidence of guidance for staff to follow consistently. We also found that where people were administered 'as required' medicines there was no protocol in place to guide staff as to when these medicines should be given and under what circumstances on a consistent basis. The registered manager told us that both processes

Requires improvement

Is the service safe?

were in place but staff were not following them as it was not available on people's records. The registered manager showed us a copy of the relevant processes and protocols for the relevant people and ensured they were in place before the end of the first day inspection.

Where people were administered medicines we saw that a Medicines Administration Record (MAR) was being used. However, the appropriate running balance to show that people were being given the right amount of medicines were not being kept. The provider's medicines procedure required that all medicines administered were counter signed by another member of staff and we found that this was not consistently being done. The registered manager told us that senior staff carried out a medicines balance check daily and we saw evidence to confirm this. The checks did not identify the concerns we had identified with medicines administration and they confirmed action would be taken to rectify both concerns identified.

We observed someone being supported with their medicines. However, the member of staff concerned did not follow the provider's medicines procedure which required them to stay with the person to ensure the medicines were administered. We found that when the member of staff left the person unattended they spilt their liquid medicine on the table cloth so the staff member concerned did not know the medicine had not been taken. The registered manager took swift action to deal with the situation as the person being administered their medicine should have been monitored to ensure the medicine was administered.

People we spoke with all told us they felt safe, A person told us they sometimes felt uncomfortable when another person 'loomed over' them. Another person said, "I feel safe and happy. They watch over me here, so I don't go out much". A relative told us, "[Person's name] has a lowered bed, for falls protection and she also has a 'falls mat' and sensors are also available". Another relative said, "It is safe, there's always someone about". Staff we spoke with understood what abuse was and who they would report it to. One staff member said, "I would report any abuse to the manager". Staff also told us they had received training in safeguarding people and we saw evidence to confirm this. A health care professional who was visiting the home told us they had no concerns with people's safety within the home.

The provider had a risk assessment process in place to identify where there were risks to how people were supported and the measures needed to reduce any risks. We saw evidence that risk assessment documentation was being reviewed regularly so where there were changes these could be acted upon. Staff we spoke with were aware of these documents and the risks to how people were supported. Where people were at risk of falling staff did not all give a consistent response to how they would deal with a situation where someone had fallen. The registered manager told us that staff all received falls prevention training and they would follow this up in the staff meeting to ensure staff all knew the expected processes to follow.

Good

Is the service effective?

Our findings

One staff member said, "I do feel supported in my job and I do receive supervision", another member of staff we spoke with said, "I have had supervisions and I have been able to attend staff meetings". We saw evidence to confirm that staff were able to receive supervision on a regular basis and receive an annual appraisal where their development and performance was discussed with them.

We found that the provider used the care certificate as part of the induction process for newly appointed staff. Care staff we spoke with confirmed this. The care certificate sets out fundamental standards for the induction of staff in the care sector. A member of staff we spoke with said, "I have had to go through an induction and shadowed more experienced staff before I could work on my own". We saw evidence that staff had access to training as part of developing their skills and knowledge to support people appropriately. We saw that the training available to staff was relevant to ensure they received the skills and knowledge needed to support people appropriately. A relative said, "They [staff] are trained, they are calm". Our observations were that staff were able to get the support they needed to support people appropriately.

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. Relatives we spoke with told us that people were able to make choices and where people were unable to, due to a lack of mental capacity, relatives were involved in the decision making process.

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 staff seeking people's consent before supporting them. Staff we spoke with told us no one would be supported without them giving their consent. People told us they were able to move around the home freely without being restricted. We saw evidence of a number of consent forms being used so people were able to give written consent. The staff we spoke with all had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). A member of staff said, "I am currently doing training on MCA and DoLS". We saw evidence to confirm that staff were able to access training and that a number of applications had been made to the supervisory body to restrict people's human rights while promoting their safety and a number of applications had been approved. Staff were also able to tell us who in the home had a authorisation to restrict their liberty and able to explain what the restriction meant. The provider notified us when restrictions to people's human rights had been approved. We discussed this with the registered manager who was unaware this had to be done and told us this would be done in future.

People were generally positive about the food they received and told us meal times were pleasurable. A person said, "Good choice, I like the bacon", someone else said, "I enjoy mealtimes the food's very good", and another person said, "The food is brilliant". We saw that water and a choice of fruit juices were freely available in reach of everyone who was capable of helping themselves. Where people were unable to help themselves staff were seen offering people hot and cold drinks on a regular basis to ensure people were kept hydrated. We saw evidence that people's fluid intake was monitored. We saw that a menu was displayed so people knew what food choices were available to enable them to make an informed choice. Where people wanted second helpings of food we saw that they were able to get this. Where people needed support to eat we saw that this was made available but it was not always in line with people's needs. We saw in one situation a relative sitting and eating with their relative and offering them support to eat and drink when needed.

We spoke with the kitchen staff who were able to explain the systems in place to ensure that information about people with specific dietary requirements was relayed to them appropriately. We found that where people's nutritional needs changed kitchen staff were made aware and informed where people had allegies to ensure the meals they had were as required.

Good

Is the service effective?

People told us that their health needs were being met. One person said, “I say I need it [a visit from the doctor], and they’ll get it”, another person told us, “He [the doctor] comes every Monday. I’m happy with him”. We saw evidence that where people saw a health professional like a doctor, dentist or optician that a note was made of the visit along with any other actions or future visits. Staff we spoke with knew what people’s health care needs were and how they were to be met.

We saw that the regular monitoring of people’s weight was in place. The appropriate screening tools were in place to monitor where there were concerns identified with pressure area care. This would ensure the appropriate relief was given on a timely manner to ensure people’s skin integrity was cared for appropriately.

Requires improvement

Is the service caring?

Our findings

People told us that staff were kind and compassionate towards them and treated them with respect. One person said, "Yes, they're [staff] caring. I don't think I'd change anything", someone else said, "They [staff] always check to see if anything needs to be done". A relative said, "Staff are always friendly". Staff we spoke with had an understanding of people's needs and how they were to be met. Our observations during the afternoon were of staff showing kindness and compassion towards people, which we did not see in the morning because staff were not spending sufficient time in the lounge to show people any compassion or kindness. We saw a number of staff sitting in the lounge after lunch with people interacting with them and relatives who were present. The atmosphere in the lounge was relaxed and people generally seemed more happy and contented in comparison to what we saw hours earlier. A person said, "I've got some good friends [referring to members of staff] here".

People told us they were able to make choices and staff would support them to do this. People knew the staff who supported them to make choices and staff knew the people they were supporting. People looked comfortable around the staff. We saw that people were involved in the decision making process as staff were seen and heard asking people questions which led to them making their own choices. Where people spent most of the time in their bedroom we saw no evidence that they were able to have regular interaction with staff. An advocate service was available to people that needed support to share their views and make decisions about the support they received where they needed it.

On the residential unit that memory boxes outside people's bedrooms were being used where people had memory loss as a way of reminding them of the important people in their lives. The lounge area was also being used a reminiscence room. There were items of furniture and other every day articles that people would have used or been familiar with as part of their life styles. We saw people eating their lunch and happily relaxing in this area.

People were able to live their lives as independently as they were able. We saw people being able to do as much as they could for themselves. We also saw people who were unable to do much relying on the support from staff. For example, we saw drinks machines in the lounges where people were being encouraged not to rely on staff but to make their own drinks.

People told us their dignity and privacy was respected. We observed staff supporting people in a way that respected their dignity and privacy and we observed people's dignity not being respected. Staff we spoke with demonstrated an understanding of how people's dignity and privacy should be respected and we saw evidence that staff were able to develop their skills, knowledge and understanding through a dignity training course that was available. For example staff told us they would ensure people were covered over during personal care type support, so their dignity would be respected. During the lunch time period on the residential unit we saw someone's dignity not being respected by the way they were left to just eat with their hands due to them not being given cutlery.

Requires improvement

Is the service responsive?

Our findings

One person said, “There are no events or activities. There are more things to do at Christmas”. Another person told us that organised outings and accompanied shopping trips were ‘occasional’ at best. We saw on the nursing unit that their were two televisions and their volume was quite loud in a small environment. We saw people sitting in the lounge, while some people seemed to show an interest in the television a number of people sat looking around the room showing no interest in the television at all. We saw an activity board displaying photographs of activities that had taken place and a program of activities that should have been happening, but we saw no evidence of activities taking place on the unit. Later on in the afternoon after people had eaten their lunch we saw an atmosphere where people were being interacted with as a result of a number of relatives in the lounge and staff having more time to spend with people. Staff we spoke with told us that the activity co-ordinator who worked on the nursing unit, was not in and they were responsible for carrying out activities. This meant that people would only be able to take part in activities when this person was on shift. It was also unclear as to how people in their bedrooms would have their preferences taken into account or be involved in any activities. The registered manager acknowledged there was a need for staff to take a more proactive role in interacting with people and understanding and providing the things they like to do.

We saw evidence that people’s preferences were being identified on the residential unit. We saw an activity co-ordinator proactively taking part in an activity with some people. We found that there were two activity co-ordinators, one on each of the two units and the one for the residential unit was available during our inspection. We spoke to them while they were carrying out activities with people to get a flavour as to how people were being encourage to take part in activities. They were aware of people’s likes and dislikes and were able to show us some of things people liked to do and how they were planned into the activities during the week. We saw displayed on the residential unit an activity plan which showed some of the activities people were able to take part in.

People we spoke with did not all remember whether they were involved in the assessment and care plan process. Only one of the people we spoke with had any recollection of being involved and agreeing to how they were to be supported. Relatives we spoke with told us they were involved. One relative said, “We were involved initially, but now it’s just a matter of keeping up the nutrition”, another said, “We take it day by day. Mum’s condition changes, but she’s happy enough”. The staff we spoke with were not all able to confirm whether they had seen people’s care plans to enable them to know what people’s support needs were. A member of staff on the residential unit said, “Yes I am able to access care records when I need them and people are reviewed six monthly”. However, a member of staff on the nursing unit told us they were unable to access care records. A health care professional we spoke with told us they attended reviews on a regular basis on the short stay unit and had no concerns as to how people were being supported. We saw evidence that confirmed that people’s needs were assessed prior to admission and a care plan created to guide staff as to how to meet their needs. We spoke to the nurse in charge on the nursing unit and they were able to demonstrate a good understanding of people’s support needs.

People knew how to raise a complaint and told us they could talk to any member of staff. A relative said, “I feel free to say it as I see it. And I wouldn’t hesitate to complain if I had to”. Another relative told us if they were unhappy the manager would sort things out for them. Staff we spoke with had an understanding as to how people could complain and what action they would need to take where someone had a complaint. We saw that the provider had a complaints process in place and a process to log all complaints so people could be responded to in a timely manner and trends could be monitored. We saw evidence that where there had been complaints they were being responded to in line with the providers standards.

Requires improvement

Is the service well-led?

Our findings

We found that regular checks and audits were being carried out by the registered manager, but they were not effective in identifying concerns we found with staffing levels, staff deployment and people's preferences not being met consistently across both units. Medicines audits took place but they had failed to identify a number of concerns we had found during our inspection. We saw evidence that the provider also carried out a regular check/quality audit on the home, which was used to ensure the registered manager was meeting the required standards. We saw that an action plan was being used to ensure identified improvements were being managed and monitored appropriately.

We found that a 'resident of the day' process was being used in the home to check the quality of documentation and records. The registered manager and staff told us that one person would be picked and all their care records would be checked over along with other areas such as the quality of bedrooms, mattresses and other important areas of their care. This would ensure every person's care package was regularly monitored to ensure they were all within the accepted quality.

People and relatives we spoke with all knew the registered manager and told us they were approachable and were seen checking on how staff supported people. Staff we spoke with told us they were able to get support when needed and both staff and health care professionals we spoke with told us the service was well led. We found that the residential unit had a friendly atmosphere and people were relaxed and comfortable around the staff. However this was not always observed on the nursing unit, the atmosphere on the morning of our visit was not friendly and staff were not proactively interacting with people. We found that on the afternoon the atmosphere was more friendly and relaxed as staff were more proactive in sitting and interacting with people.

We found that there was a management structure in place that staff understood and knew who to contact when the registered manager was not available or they were working out of hours.

We saw evidence that people were able to share their views when they wanted. The registered manager had regular meetings with people and relatives to discuss the service people received. The provider recently made available an electronic tablet in the reception area on which people, relatives and visitors could leave their views on the service. This was a computer generated system which provided instant analysis of the feedback. We found that questionnaires were also made available as a way of gathering people's views. The registered manager told us questionnaires were used to gather people's views as a way of improving the service. We saw evidence to show that people, relatives and staff were sent out questionnaires on an annual basis to complete and they were being returned. The most recent survey for 2015 had just been analysed and the findings/action plan to be made available.

Staff we spoke with told us there was a whistleblowing policy in place and they were able to explain how it would be used where staff had concerns about people's safety on an anonymous basis.

We saw minutes of staff meetings where the registered manager discussed their expectations of staff in supporting people amongst other topics. The registered manager also told us about an award presented to staff at meetings as a way of celebrating and recognising where staff have performed well.

Staff we spoke with were able to explain that accidents and incidents were recorded and passed to the registered manager. The registered manager confirmed that they monitored accidents and incidents. A three monthly falls prevention audit was done to analyse why falls happen as a way of reducing falls within the home.

The registered manager knew and understood the requirements for notifying us of all death, incidents and safeguarding alerts as is required within the law.

We found that the provider did not return their completed Provider Information Return (PIR) as we had requested. We were informed by the registered manager that a form was not received for this service.