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Ashley Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 11 May 2015. Ashley Care Centre provides accommodation for persons who require nursing or personal care and the treatment of disease, disorder or injury for up to 49 people. On the day of our inspection 47 people were using the service and there was a registered manager in place.

At the last inspection, in June 2015, the service was rated Good. At this inspection we found that the service remained Good. However, the rating for the Effective domain has changed from Good to Requires Improvement.

People continued to receive safe care. Safe staff recruitment processes were in place and people were protected from the risk of harm. Enough staff were in place to provide care and support to people to meet their needs. Safe medicine management processes were in place and people received their prescribed medicines safely.

Since our last inspection we found improvements were needed to the way the principles of the Mental Capacity Act 2005 (MCA) were used when decisions were made for people. People were supported to lead a healthy lifestyle. Records used to record current risks for some people in relation to their nutritional needs required updating. Staff were well trained and understood how to provide effective care and support for people. Staff received regular supervision of their work and were encouraged to develop their roles through gaining relevant external qualifications. Effective relationships were in place with external health and social care professionals to support people with their day to day health needs.

People were treated with kindness, dignity and respect by the staff. People had developed positive relationships with staff which contributed to a positive atmosphere within the home. People's care records were detailed and personalised which enabled staff to support people in line with their personal preferences. People felt able to make a complaint if they needed and were confident any concerns raised would be acted on. Effective systems were in place to manage any complaints that the provider may receive.

The service continued to be well-led. The registered manager, new to the role since the last inspection and their clinical lead, managed the home enthusiastically and professionally. People, relatives, staff and professionals commented positively about their leadership. There was a positive ethos and an open culture at the home resulting in an enjoyable working environment for staff and a calm and friendly atmosphere for people living there. Effective auditing processes were 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?

Good

The service remains good.

Is the service effective?

Requires Improvement

The service has changed from good to requires improvement for this question.

Records did not always reflect that the principles of the Mental Capacity Act 2005 (MCA) had been appropriately applied when decisions were made for people who lacked mental capacity to make specific decisions themselves.

People were supported to lead a healthy lifestyle. Records used to record current risks for some people in relation to their nutritional needs required updating.

Staff were well trained and understood how to provide effective care and support for people. Staff received regular supervision of their work and were encouraged to develop their roles through gaining relevant external qualifications.

Effective relationships were in place with external health and social care professionals to support people with their day to day health needs.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Ashley Care Centre

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 checked 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 comprehensive inspection was carried out on the 11 May 2017 by one inspector, a specialist advisor (nurse) 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, the provider completed a Provider Information Return (PIR). 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 also reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During the inspection we spoke with six people living at the home, four relatives, the cook, three members of the care staff, a nurse, the clinical lead and the registered manager.

We looked at care records relating to nine people living at the home as well as medicine records for many others. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

During the inspection we spoke with or contacted via email four health and social care professionals who gave us their views on the quality of the service provided

Good

Is the service safe?

Our findings

People received care from a staffing team who protected them from experiencing avoidable harm and kept them safe. A person we spoke with said, "I feel safe, if I didn't I'd soon put my foot down!" Another person said, "It's quite nice in here, very comfortable, I'm safe here it's nice and quiet there are no rowdies [people speaking loudly]." A relative said, "[My family member] is safe here, the staff are really good."

The risks to people's safety and welfare had been assessed and regularly reviewed to ensure that people were kept safe. Processes were in place to ensure people were not at risk of experiencing avoidable harm or abuse. Where needed, referrals had been made to the appropriate authorities. Staff spoke knowledgably and confidently about what they would do if they thought people were at risk of harm. Where accidents or incidents had occurred, these were investigated, with changes made to people's care and support needs to reduce the risk or reoccurrence. Records showed that although the number of unwitnessed falls was already low, due to the increased analysis and investigation by the registered manager and clinical lead, there had been a further reduction over the past three months.

People felt there were enough staff in place to keep them safe and to respond to their needs. One person said, "I think there are enough staff." Another person said, "I seldom wait for help, I think there are enough (staff)." A relative said, "There are mostly enough staff, although they do seem busy all the time."

Records showed people's level of dependency had been assessed to help determine the number of staff needed to support people. We found the number of staff deployed to work at the home over the course of the previous month on the whole met the required number. The registered manager told us occasionally they may be one member of staff down, but was confident that when their newly appointed care staff had completed their pre-employment checks and induction, the numbers would improve consistently to the required number. Some staff did raise concerns in relation to staff numbers on duty, but they were also aware that recruitment for new staff was under way. Our observations throughout the inspection showed people received care and support when they needed it. Safe recruitment processes were in place to reduce the risk of unsuitable staff being employed to work at the home.

People told us they were happy with the way their medicines were managed. One person described the way they liked to take them. "I like to take all my pills in one go", which they did when a member gave them a pot of several pills. The person then said, "[Staff member] knows I take them all at once."

Records showed there were clear medicine management systems in place to ensure people were protected from the risks associated with medicines. This included; photographs of each person to aid identification to prevent medicines being given to the wrong person, recording of how people liked to take their medicines and detailed records showing when a person had taken or refused to take their medicines. People's records showed they received their medicines when they needed them. Medicines were stored, handled and administered safely. We did note a small number of liquid medicines did not have the date recorded they were opened, which could increase the risk of their effectiveness being compromised due to the medicines being in use for longer than the recommended timeframe. We raised this with the registered manager who

told us they would ensure these were checked as part of their medicines audit.

Requires Improvement

Is the service effective?

Our findings

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

People and their relatives all felt that staff requested their, or their family member's, consent before providing care and support. One person said, "I can wander around, I do what I want to." The staff we spoke with were able to explain how they gained consent from people and we saw staff doing so during the inspection.

When we checked people's care records to see whether they were completed correctly and in line with the principles of the MCA, we found not all documentation was correctly completed. Relatives had been asked to give their consent to a wide range of care provisions for their family members. We saw documents signed by relatives giving consent for the use of photographs in the care records, receiving annual vaccinations and the use of bed rails and sensor mats. Whilst some of these relatives had the legal authority to do so, others did not, and this was not made clear on people's records.

When people were unable to make some decisions for themselves a mental capacity assessment was completed for all activities of daily living. However, there was no documentation to demonstrate how decisions that were made for people following these assessments had been made. These are called best interest decisions. When a decision was made this was referred to in each person's care records, however the information was limited and did not contain details of who was involved with the decision, or whether it was the least restrictive option. This meant decisions could be made by people who were not authorised to do so and may not have always been in people's best interest.

We discussed this with the registered manager and the clinical lead. They advised us they would complete a full review of all care records and would provide us with examples of revised documentation after the inspection, which they have now done. This has now started to reduce the risk of reoccurrence, however this will be reviewed at the next inspection to ensure the improvements have been sustained.

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 are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for three people and found staff adhered to the terms of the DoLS. We also saw examples of do not to attempt resuscitation orders (DNACPR) in place. These had been completed appropriately.

People and their relatives told us they felt staff were well trained and understood how to support them or their family member. One relative said, "Staff are trained; they know what they are doing." This relative appreciated that staff noticed the change in their family member when they developed a condition and

acted upon it quickly. Another relative told us they felt the staff did whatever they could to make their family member happy. They also said, "[My family member] is okay here, they seem to try and make them comfortable and happy. [My family member] is contented." A third relative said, "Staff are well trained, especially given [my family member's] medical conditions. I couldn't recommend the home highly enough."

People received care and support from a staff team that had a training programme in place designed to equip them with the skills needed to support them safely and effectively. Staff performance was regularly reviewed and staff felt supported by the registered manager. Staff were encouraged to develop their knowledge further by obtaining externally recognised qualifications.

People who may present behaviours that may challenge due living with dementia or other mental health conditions were protected by staff because appropriate assessments on how to support them had been carried out. We observed staff respond effectively to people who showed signs of distress or agitation.

People and their relatives were generally positive about the food provided at the home. One person said, "The food's quite good, it's not perfect, but it's quite good." Another person described the food as, "okay", whilst a third person said, "The food's very good." A relative described the process for helping their family member choose their food and said, "They use two plates so [my family member] can choose." We observed staff providing people with visual choices at meal times.

Nutritional risk assessments were completed and care plans were in place for eating and drinking. Staff were able to explain how they ensured people living with diabetes were supported to lead a healthy lifestyle to reduce the risk of a hypoglycaemic or hyperglycaemic seizure, which can occur when a person's blood sugar levels are too high or too low. One staff member told us they ensured a person had, "a good supper before they went to bed", and ensured nutritional supplements were given to those who needed them. However, we found some people's care records required updating as these processes were not always recorded.

People's weight was monitored and referrals were made to a dietician or speech and language therapist when problems were identified or if people had lost weight. We did note that food and fluid charts were used to document people's food and fluid intake to help staff monitor any significant changes.

We observed the lunch time meal being served. The meal time was pleasant, peaceful and unhurried. We saw the registered manager sat with people and they ate their lunch together. Where people needed support with eating their meals staff were there to support them. For example, we saw one member of staff supporting a person with a patient and careful approach, getting up close to the person, maintaining their attention for each spoonful of food; chatting and encouraging them throughout.

People were supported to maintain a healthy, balanced diet and those at risk of not eating and drinking enough received the support that they required to maintain their nutritional intake. Where people were at risk of dehydration or from eating and drinking too much or little, monitoring of their consumption was recorded. We did note that the total amount people consumed each day was not always recorded which could make it difficult to monitor people's on-going progress.

People had regular access to healthcare professionals and staff were vigilant to changes in people's health. The professionals we spoke with during and after the inspection spoke positively about the support people received with their day to day and health and care needs. Changes in people's health were recognised quickly by staff and prompt and appropriate referrals were made to healthcare professionals.

Good

Is the service caring?

Our findings

People developed positive relationships with staff and were treated with compassion and respect. One person we spoke with said, "The staff are smashing, we couldn't get any better." Another person said, "I think it's marvellous, I'm looked after well, they're kind." A third person said, "Staff are kind and friendly, nothing goes wrong. I've never had any problems with anyone." A relative said, "They are all kind and caring, they sometimes may be a little frazzled, but I've never seen anything untoward."

We observed staff engaging with people in meaningful conversation. Outside each person's bedroom and also within their care records were details of their interests, life history and likes and dislikes. Staff used this information, along with information about people's daily routines to form warm relationships with people.

People were offered choices ranging from where they would like to sit, to the food they would like to eat. People felt involved with decisions and appreciated staff listening to and respecting their wishes. One person told us staff listened to them and really understood what was important to them. There was a calm and relaxed atmosphere at the home, with people and staff comfortable in each other's company.

Staff treated people with dignity and respect. A relative described the process when staff supported their family member with their personal care. "They will take [my family member] to their room or put a screen round them if anything needs checking." Another relative said, "All the staff treat [my family member] with dignity, I've never, ever heard a raised voice."

We observed staff speak respectfully and discreetly with people when discussing personal matters such as their personal care needs. People's privacy was respected by staff. When people wished to be left alone staff respected their wishes. There was plenty of private space available throughout the home for people to meet with family or friends or to be on their own.

Staff told us they felt they made a difference to people's lives, with staff explaining some positive examples where people's lives had improved. Staff encouraged people's independence, but were available to assist people if they needed them.

Good

Is the service responsive?

Our findings

People received care and support that met their individual needs. A range of assessments and care planning documents were in place that had been completed prior to the person coming to live at the home. These had been completed with the input of each person where able, and with relatives where appropriate. Each of the records were regularly reviewed to ensure they met people's current needs. The majority of the records we looked at were up to date and reflected people's current health needs. A small number of the records contained contradictory information. For example, the way a person received their medicines was recorded differently in the care and medicines records. The registered manager told us they would ensure all care plans were reviewed to ensure they all reflected people's current needs. However, the health care professionals we spoke with all felt the staff responded well to people's health needs.

Staff were knowledgeable about people's individual needs and spoke confidently about the support they provided. Staff knew people's personal preferences and used this information when supporting people.

People were supported to follow their interests and take part in social activities. A person described the activities at the home. "I'm into them all, nothing in particular. We don't get bored; we don't get time to get bored." A relative said, "[My family member] does enjoy the singers when they come, they do a good job."

There was a relaxed approach to supporting people with activities. Staff interacted with people on a one to one basis for short periods. For example, a person was given a nail manicure, another person sat with a member of staff and went through a photograph album with them and a third person was given a therapeutic doll to cuddle, which they enjoyed. We saw others baking with staff and heard them discussing the bingo game due to be played later, with one person stating they enjoyed bingo. People were also supported with contributing to domestic tasks around the home. Staff told us one person liked to assist them with the dusting and another washed pots as they were accustomed to do this at home and liked to help.

People felt able to make a complaint if they needed and were confident it would be acted on. One person told us they had not made a complaint but they knew who to speak to if they needed to. They also said, "I'd be able to speak to the high ranking who run the place. I've had no problems at all, I've never had any." A relative said, "I would go to [my family member's] named nurse or the manager, they would solve any problems, little things have been resolved."

A complaints policy was in place. Records showed when complaints were received they were handled appropriately and in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

A new registered manager was in post and with the support of an experienced clinical lead, the home was well led with an effective management, nursing and care staff team in place. People, their relatives, staff and healthcare professionals spoke positively about the registered manager and the clinical lead. Many of the relatives said they found the registered manager approachable, with one relative saying, "I can talk to the manager." A staff member said, "They are much more involved and on the floor than previous managers I have worked with." A healthcare professional described them as "approachable and proactive."

Staff spoke positively and passionately about their role which contributed to a positive atmosphere and open culture within the home. We saw people, staff and members of management interacting well, with the registered manager sitting with people to eat their lunch and talk with them about their day. Staff felt the management team valued their opinions and acted on them. One staff member said, "They do listen to us and I am confident if I raised a concern it would be dealt with." Records showed staff meetings and meetings for people who lived at the home and their relatives were held regularly. A relative said, "There are regular meetings and we've had a couple of surveys, they make sure everything runs okay." Feedback from these meetings and questionnaires designed to gain people's views on the quality of the service provided resulted in plans for continued improvement at the home.

Quality assurance systems were in place to help drive improvements in the home. A wide range of audits were in place which enabled the management team to identify any areas of concern and to act on them quickly before the quality of the service was affected. Audits included regular reviews of the environment, people's care records and medicines. Monthly reporting was provided to commissioners of the service. This enabled the service to operate transparently, informing the commissioners of any areas of increased risk and to agree the actions needed to make the required improvements.