Mr David Roland Green

Ashwood Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 and 23 January 2017. The inspection was announced.

Ashwood Care provides personal care services to people in their own homes. At the time of our inspection there were 80 people receiving care and support from the service. They were supported by 20 care workers, a supervisor, an office co-ordinator and a registered manager.

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.

The service had a process in place to assess the risks to the health and well-being of people and staff. However, once identified there was not always clear guidance to ensure that the risks were managed safely. Staff demonstrated a good understanding of how to protect people from abuse and avoidable harm and the provider had suitable processes in place if staff needed to report any concerns. Safe recruitment practices were followed to ensure staff were suitable to work in a care setting. There were enough staff to support people safely. People were supported safely to take their medications and medication administration records (MAR) charts were completed fully.

Staff did not all receive regular mandatory training to ensure they maintained the skills and knowledge to carry out their roles effectively. Where people required support to maintain their nutrition and hydration, charts were not always completed appropriately. Supervision, observation checks and appraisals were completed regularly. Consent was sought from people before personal care was provided. Staff demonstrated a good knowledge of the Mental Capacity Act and how to apply this in everyday practice.

Safeguarding notifications were not sent to the Commission. Auditing to monitor and improve the quality of service provision was not undertaken effectively. Staff felt well supported by the registered provider. People and staff received questionnaires to provide feedback about the service .

People were positive about the care they received. Care was provided by regular staff who knew people well, and with whom they had developed a good rapport. People's dignity and privacy was respected. Care calls were occasionally late but there were no missed calls.

The provider's initial assessment, care planning and reporting systems resulted in people receiving care and support that met their needs and was delivered according to their preferences. People were supported by staff who knew them well as the provider ensured that there was consistency in staffing people's calls. People knew how to make a complaint if they had any concerns. Complaints were logged, investigated and followed up.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Although risk assessments had been completed, once identified the risks to people's health and wellbeing were not always managed safely.

Staff knew how to recognise signs of potential abuse and avoidable harm.

Safe recruitment practices were followed.

People were supported safely with their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not all receive mandatory training updates to ensure they maintained the skills and knowledge to carry out their roles effectively.

Nutrition and hydration charts were not always completed appropriately.

Staff gave good examples of seeking consent before providing personal care.

The provider supported staff with regular supervision, observation checks and appraisals.

Is the service caring?

Good

The service was caring.

Care calls were occasionally late, but there were no missed calls.

People had developed caring relationships with the staff supporting them.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care plans were comprehensive and supported people according to their needs and preferences.

The provider ensured that there was consistency in staff covering people's calls.

There was a complaints process in place and any complaints received were dealt with in accordance with the provider's policy and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of robust auditing systems in place to monitor and improve the quality of service provision.

Safeguarding notifications had not been sent to the Commission.

Staff spoke positively of the supportive management team.

The provider sought feedback about the service from people and staff.

Ashwood Care

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 20 and 23 January 2017 and was the first inspection carried out under the Care Quality Commission's new inspection regime where a rating is provided. We gave the registered manager 48 hours' notice of our visit to make sure people we needed to speak with would be available. One inspector carried out the inspection.

Before the inspection, we reviewed previous inspection reports and other information we had about the service, including information from staff and people who used the service and notifications provider had sent to us. A notification is information about important events which the provider is required to tell us about by law.

After the visit on 23 January we spoke with five people who used the service and a relative. We spoke with the registered provider, the office co-ordinator and four members of staff.

We looked at care plans and associated records of five people. We reviewed other records relating to the management of the service, including risk assessments, quality survey and audit records, incident and safeguarding reports, training records, policies, procedures, meeting minutes and five staff records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe being supported by staff at Ashwood Care. One person said, "I see the same carers, they keep me safe, they know me really well." A relative said, "if I had any concerns about safety I wouldn't let [carers] look after [relative]. They are a great bunch."

Risks associated with people's health and wellbeing had been identified and assessed. However, risk assessment documents did not contain the expected guidance to address and manage the risks identified. For example, one person was assessed as being at risk of malnutrition and another of demonstrating behaviour that challenges, yet care plans did not contain the appropriate guidance for staff to follow if these risks presented. Whilst many staff had been employed at Ashwood Care for a long period of time, there was a possibility that newer members of staff would not have sufficient guidance to manage people's individual risks, putting both staff and people at risk.

The failure by the registered provider to do all that was reasonably practicable to mitigate risks to people and staff was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave good examples of how to recognise signs of abuse and avoidable harm. Staff felt confident that if they reported any areas of concern, the manager would investigate robustly to a satisfactory outcome. Staff members told us that they knew how to contact outside agencies with any safeguarding issues or concerns. Not all staff however had received up to date annual safeguarding training with some staff not having completed refresher training since 2011. There was evidence that safeguarding investigations had been completed and the local authority safeguarding teams had been notified appropriately. However, notifications regarding safeguarding had not been sent to the Care Quality Commission (CQC) as required.

The failure by the registered person to notify the Comission without delay of safeguarding incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We recommend the registered manager review the CQC Guidance for providers on meeting the Care Quality Commission (Registration) Regulations 2009 .

People were supported with their medicines safely. People's support with their medicines was mainly limited to prompting and reminding them. Staff supported people with prescribed medicines only, and where appropriate these were provided in a blister pack system. We looked at the Medicine Administration Records (MAR) charts for five people and they were all completed fully. The provider supported staff with medicines training; however, annual medicines refresher training was not always completed with some staff not having completed their training since 2011. Staff confirmed that there were no people receiving their medicines covertly.

There were enough staff employed to support people safely. The registered manager had been trying to recruit additional care workers but told us that it had been difficult to recruit new care staff. This meant that staff based in the office had been covering additional calls when required. Rotas were completed on an electronic system and there were no gaps in calls being covered. Staff did not feel that their workloads were unmanageable. Occasionally calls were late and people told us that the office co-ordinator or registered manager would contact them to advise of the delay. There were no missed calls.

The provider followed safe recruitment practices. We looked at five staff recruitment files and observed that the registered manager had sought appropriate referencing, photographic identification and Disclosure and Barring Service checks (DBS) for all employees. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People told us they felt supported by staff who had the right skills and experience to care for them well. One person said, "yes, they know what they're doing. They always seem to." Another said, "I see the same carers and they know exactly how to look after me, I would tell them if they didn't but I never need to."

Staff had completed mandatory training to enable them to initially acquire the appropriate skills and knowledge to carry out their roles effectively. The provider's training policy stated that annual refresher training should be completed by all staff. The training provided included subjects such as moving and handling of people, safeguarding adults, fluids and nutrition and privacy and dignity. However, all five of the staff records we reviewed had at least one element of their annual mandatory training out of date, some as far back as 2011. We discussed this with the registered manager. He advised that some elements of the training provided, in particular the moving and handling of people, which was provided by an external training company, was a three yearly refresher course. This could mean that staff were not up-to-date with the latest moving and handling practices and techniques potentially causing a risk to people and staff while care was being provided. This was again highlighted with the registered manager who agreed to take action to address the gaps in staff training. The provider offered an induction to new staff which included shadow shifts alongside experienced colleagues. Staff were supported to follow The Care Certificate and evidence of some staff having undertaken training alongside this was observed during inspection. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

The failure by the provider to ensure that staff are suitably qualified, skilled and experienced to ensure that they can meet people's care needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had limited involvement with supporting people to eat and drink according to a balanced, healthy diet. However, during initial assessments some people had been identified as being at risk of not eating or drinking enough. This information had been transferred into people's care plans and food and fluid charts had been started to ensure that those at risk of malnutrition could be monitored. However, we observed upon reviewing people's care plans that the charts had not always been completed, with many gaps evident in daily charts. This could mean that those at risk of not eating and drinking enough were not being appropriately monitored which could have adversely affected a person's health and wellbeing. We spoke to the registered manager about this and they agreed to ensure that charts were completed fully and that staff were aware of the risks to people if they were not.

The failure by the provider to ensure that the risks to people's nutritional and hydration needs were met is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported by the provider with regular supervision sessions and spot checks. This gave staff the opportunity to discuss any areas for development they may have had and to receive feedback regarding

their performance. Staff told us that they felt the supervision was helpful and that they were able to raise any concerns or issues they might have with their line manager which would be addressed appropriately.

The Mental Capacity Act 2005 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 Act. The registered manager was aware of the Mental Capacity Act 2005 and its associated code of practice. Staff received training in mental capacity, and were aware of the principles of the Act.

Staff gave us examples of how they obtained people's consent before supporting them with their personal care. One care worker said, "If a service user didn't want me to help them with personal care I would have a chat with them, try to encourage them to let me help. Sometimes if you leave them for a few minutes and then come back that helps. If not, I would write it in the book and tell the office." People we spoke to confirmed this.

People were supported to access their GPs or community nurses when they required them. There was evidence seen in care records of staff having made telephone calls to the office for the co-ordinator to arrange appointments for people when they were feeling unwell.

Good

Is the service caring?

Our findings

People told us they had caring relationships with their care workers who knew them well. One person said, "My carer is lovely, I look forward to her coming in to have a chat more than anything else." A relative said, "They're all nice, all of them – very kind. I've never had a problem. If I have a worry I phone [registered manager] and it's sorted."

People's care plans contained evidence people were involved in decisions about their care. Care plans and risk assessments were reviewed with people and their families. Care plans were written in a way that encouraged people's independence and involvement in their care and support. During spot checks, the care supervisor would ask people how they felt about the care provided and if they were happy with how they were supported. People told us that they felt involved in their care and that they had no concern about suggesting changes or contributing to their care plans.

Staff gave good examples of when they had respected people's privacy and dignity whilst providing personal care. People told us about practical measures staff used during personal care routines to respect people's privacy and dignity, such as staff closing doors, drawing curtains and covering people while assisting with washing. One person said, "I never have to worry. My carers are like my friends, they treat me well, very kind." Another person said, "I can do some things myself, if I can't do something then they help me, that's the way I like it. Couldn't do without them though."

The service had received a number of compliments about the staff and service provided. One comment said, "[name] was so pleased to see [registered manager] and [staff member] from Ashwood who went to see her in hospital and how wonderful she thinks the staff are." Another said, "[relative] called to say thanks for going out to see his [relative] out of the hours of his [relatives] visiting times." Another said, "[name] called to say a massive thank you for helping to arrange transport to get [name] to the hospital at short notice before [relative] passed away, she could not show enough gratitude for what [registered manager] had done."

Good

Is the service responsive?

Our findings

People said they were satisfied their care plans met their needs. One person said, "My care plan is alright, the girls look after me well and if anything changes they know about it." Another person said, "One of the girls from the office comes out sometimes. She changes the book and checks I'm ok."

People's care plans reflected their individual needs and detailed the care and support to be provided. Peoples preferences were considered, for example, one person's plan stated what they liked for their breakfast and how they liked their tea. Another stated what types of drinks the person preferred to have throughout the day. The care plans recorded the objectives of the care provision and the individual person's desired outcomes. Staff confirmed the care plans contained sufficiently detailed and personalised information so as to enable them to support people according to their needs and preferences.

Care plans were kept in the office as well as in the person's home. The plans included information regarding maintaining a safe environment, medication, mobility, eating and drinking, personal ability, personal care and communication. There were also details of the next of kin, medical conditions, risk assessments and reviews. Generally records were comprehensive and completed fully. They were detailed according to the individual persons' needs. Reviews were completed by office staff regularly. If persons' needs changed, for example, if someone had been in hospital, staff would not wait until the next scheduled review to alter the care plan, it would be done as soon as possible post discharge. However, risk assessments and nutrition and hydration charts were the exception to this and were not completed satisfactorily.

Care workers recorded the daily care they provided in logs which were kept in people's homes. This information provided details of the care provided to people and observations of their general well-being and appearance. This information would be read by the staff member who next visited, which helped to give them an up-to-date picture of the person's general well-being.

Copies of the complaints policy were kept in people's homes. One person said, "If I wanted to complain about anything I would phone the office and speak to [registered manager] or [staff member] and they'd sort it out. I'm not worried." Complaints were dealt with in accordance with the provider's complaints policy. The registered manager recorded complaints and concerns received on the services' electronic system. These had been dealt with in a timely manner and to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with described the service as being caring and were positive about the registered manager. One person said, "[registered manager] is very kind and you can talk to anyone in the office about anything." Another person said, " I never have any problems really. I did phone in one day about my tea time call but they dealt with it and it's sorted now."

Notifications had not been sent to the Commission. Records showed safeguarding concerns had been received by the service, been investigated and had been dealt with in line with the provider's policy. However, the Commission had not been notified of these concerns, following discussion with the registered manager it was agreed that notifications would be sent to the Commission as appropriate.

The registered manager did not have a system of audits in place to review and monitor the effectiveness of care plans and daily logs. This had prevented them from detecting our concerns regarding the lack of risk assessment guidance and the lack of completion of the nutrition and fluid charts for those people identified as being at risk of malnutrition. This was discussed with the registered manager during inspection who agreed to review systems to prevent reoccurrence.

The failure by the provider to ensure that there were systems and processes in place to assess, monitor and improve the quality and safety of the services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's feedback was sought during regular quality visits and through questionnaires. The last questionnaire was sent out in September 2016 and the outcome of this was largely positive. Feedback received during quality visits to clients' homes was also positive and changes were made as a result of suggestions gleaned during feedback. An example of this was the time of a call which was altered following a discussion with a person who was unhappy with her morning call times. People told us they felt able to discuss any concerns with the registered manager and office team. They told us that the registered manager was very kind and would always listen, people were positive about the management of the service.

Staff told us they enjoyed working for Ashwood Care and were generally positive about working there. One care worker said, "The management are great, really supportive. I'd only really change the training." Another said, "I've been here a while, they are good in the office if you need anything." There were no staff meetings held but staff felt that due to the regular supervision and observations they were updated with learning about best practice or from any incidents that may have occurred due to the regular contact with their line managers. Staff questionnaires were also sent out but the service did not always receive a high level of response.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The failure by the registered person to notify the Comission without delay of safeguarding incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure by the registered provider to do all that was reasonably practicable to mitigate risks to people and staff was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The failure by the provider to ensure that the risks to people's nutritional and hydration needs were met is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good

	governance The failure by the provider to ensure that there were systems and processes in place to assess, monitor and improve the quality and safety of the services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	**Regulation**
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure by the provider to ensure that staff are suitably qualified, skilled and experienced to ensure that they can meet people's care needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.