Ashton Care Homes Limited

Ashton House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good

Overall summary

We carried out an unannounced comprehensive inspection of at Ashton House on 14 April 2015. Following that inspection we received information of concerns that people were not always receiving the care they needed which could place people at risk of harm. As a result we undertook a focused inspection to look at those areas of concerns. We looked at the key questions, is the service safe and effective. This report only covers our findings in relation to those areas. You can read the report from our last comprehensive inspection in April 2015, by selecting the 'all reports' link for Ashton House on our website at www.cqc.org.uk.

The inspection took place on the 28 July 2015 and was unannounced.

Ashton House is a large detached property, consisting of a main house and purpose built wing. Ashton House is registered to provide nursing care for up to 91 older people and people living with dementia. Accommodation is provided over three floors, with passenger lifts providing access between floors. On the day of our inspection 75 people were using the service.

The service did not have 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. We had received an application for the manager of the service to become the registered manager, which was currently being processed.

On the day of the inspection the provider was being supported by external agencies staff who provided guidance and support in care and nursing practices, this was due to a number of concerns that were currently being looked into by the local authority.

Concerns had been raised that there were not enough experienced and permanent nursing staff at the home. The provider and manager told us of the issues and

Summary of findings

difficulties they had and the plans they had in place to ensure the home was run by competent nurses who would be employed permanently. In the interim the provider was using regular agency staff.

Staff did not always take appropriate action following accidents and incidents to ensure people's safety although they were recorded in the accident and incident book, we found the recording of incident and accidents was not always consistent and therefore it was not always clear what action was being taken. Some had limited information to be followed up which could have an impact of people's safety.

The experiences of people were positive. People told us they felt safe living at the home, staff were kind and compassionate and the care they received was good. One person told us "I like it here, I feel safe and the staff are nice". We observed people at lunchtime and through the day and found people to be in a positive mood with warm and supportive staff interactions.

Staff supported people to eat and they were given the time to eat at their own pace. The home met people's nutritional needs and people reported that they had a good choice of food and drink. One person told us "The chef is very good we have lovely meals". Staff were patient and polite and supported people to maintain their dignity and were respectful of their right to privacy.

The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to get the medicine they needed when they needed it. People were supported to maintain good health and had access to health care services when needed.

People's individual needs were assessed and care plans were developed to identify what care and support they required. People were consulted about their care to ensure wishes and preferences were met. Staff worked with other healthcare professionals to obtain specialist advice about people's care and treatment.

Staff had received essential training and there were opportunities for additional training specific to the needs of people living at the home. Staff had received one to one supervision meetings with their manager.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

Following this focused inspection, we have revised the rating of safe from 'Good' to Requires Improvement. However, the overall rating of 'Good' remains.

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

Some aspects of the service were not consistently safe.

Records of accidents and incidents were found to be inconsistent, some had limited information to be followed up which could have an impact of people's safety.

People told us they were happy living in the home and they felt safe. Staff had received training on safeguarding people from abuse and were clear about how to respond to allegations of abuse.

Medicines were stored appropriately and associated records showed that medicines were ordered, administered and disposed of in line with regulations.

Is the service effective?

Good

The service was effective. People received support from staff who understood their needs and preferences well. People were supported to eat and drink sufficient to their needs.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had an understanding of and acted in line with the principles of the Mental Capacity Act 2005. This ensured that people's rights were protected in relation to making decisions about their care and treatment.

People had access to relevant health care professionals and received appropriate assessments and interventions in order to maintain good health.

Staff received on going professional development through regular supervisions, and training.

Ashton House

Detailed findings

Background to this inspection

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

We carried out an unannounced comprehensive inspection of at Ashton House on 14 April 2015. Following that inspection we received information of concerns that people were not always receiving the care they needed which could place people at risk of harm. As a result we undertook a focused inspection to look at those areas of concerns by looking at the key questions, is the service safe and effective. This report therefore only covers our findings in relation to those areas. You can read the report from our last comprehensive inspection in April 2015, by selecting the 'all reports' link for Ashton House on our website at www.cqc.org.uk.

The inspection took place on the 28 July 2015 and was unannounced. The inspection team consisted of three inspectors and a specialist in nursing care.

Before the inspection we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection. We contacted selected stakeholders including the local authority to obtain their views about the care provided.

During our inspection we spoke with twelve people and five relatives, five care staff, one activity coordinator, four registered nurses, the manager, the deputy care manager and the provider. 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. After the inspection we spoke with three health care professionals who worked with people at the service to gain feedback.

We reviewed a range of records about people's care and how the service was managed. These included the care records for eight people, medicine administration record (MAR) sheets, staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining area during the day. We spoke with people in their rooms. We also spent time observing the lunchtime experience people had and a nurse administering medicines.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us "I like it here, I feel safe and the staff are nice". Another person told us "I feel very safe here the staff are very good you know." A relative told us "We have no concerns here, as a family we feel our relative is in very good hands they have done everything possible to make them as comfortable as possible". Another relative told us that their loved one was very happy in Ashton House after moving from another care home and had settled in quickly. Despite people's high praise of Aston House, we did find areas of practice which were not consistently safe.

Staff did not always take appropriate action following accidents and incidents to ensure people's safety although they were recorded in the accident and incident book, we found the recording of incident and accidents was not always consistent and therefore it was not always clear what action was being taken. For example, some had limited information to be followed up such as monitor closely with no further detail, which could have an impact of people's safety.

Subsequent to the inspection we were informed by the local authority of incidents and events that the provider should have referred to them under local safeguarding guidance. These remain under investigation. People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the policy and procedures if it occurred. They told us they had received training in keeping people safe from abuse and harm and we confirmed this from the staff training records we looked at. Staff described the sequence of actions they would follow if they suspected abuse was taking place. They said they would have no hesitation in reporting abuse and were confident that management would act on their concerns. Staff were also aware of the whistle blowing policy and the option to take concerns to appropriate agencies outside the home if they felt they were not being dealt with effectively. Staff could therefore protect people by identifying and acting on safeguarding concerns quickly. There was some on going investigations into multiple referrals being made around safeguardings. This had led to the local authority safeguarding team undertaking some temporary key supervisory roles within the service.

People felt there was enough staff to meet their needs. One person told us "There seem to be plenty of staff from what I've seen". Another person told us "I think there is enough staff". Staff told us that they felt there were always enough staff at all times of the day. Staff rotas showed staffing levels were consistent over time. Agency nurses were being used to maintain the nursing staff levels. Consistency was being maintained by employing the same nursing staff to help ensure the continuity for people and record keeping. Staff confirmed that they felt there was enough staff to meet people's needs. The provider and deputy care manager regularly assessed care needs and adjusted the number of staff on duty based on the needs of the number of people using the service. The deputy care manager told us "If we require more staff I will speak with the provider who will arrange this, recently we increased staff to ensure there was always somebody in the main lounge at all times".

There had been some concerns raised around the care and support provided by the nursing staff and if there were enough experienced and permanent nurses at the home. The provider and manager told us of the issues and difficulties they had in employing and maintaining nursing staff and the plans they had in place to ensure the service was run by competent nurses who would be employed permanently. The provider told us "We are having to use some agency nurse's while we are recruiting permanent nurses. We work closely with the agency to ensure we have the same nurse's for continuity of care for our residents". They also told us of the interviews they had held and were taking place and how they had increased their advertising in various areas. The provider and manager told us they wanted to attract the right people for the job and how a new nursing structure would be put in place when they had been recruited. The provider was also increasing the level of nurses on each shift. We were also shown a document called "home goals". This contained action plans, improvement plans and the planned team structure when staff had been recruited. The local authority were also supporting the nursing staff with their own nurses who provided guidance and support.

Each person had an individual care plan. Care plans followed the activities of daily living such as communication, people's personal hygiene needs, continence, moving and mobility, nutrition and hydration, breathing, pain control, sleeping, medication and mental health needs. The care plans were supported by risk

Is the service safe?

assessments, these showed the extent of the risk, when the risk might occur, and how to minimise the risk. For example a Waterlow risk assessment was carried out for all people. This is a tool to assist and assess the risk of a person developing a pressure ulcer. This assessment takes into account the risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. These allowed staff to assess the risks and then plan how to alleviate the risk for example ensuring that the correct mattress is made available to support pressure area care. The deputy nurse explained that the care plans and risk assessments were audited on a monthly basis or when required.

People's general health was routinely monitored. Some people were noted to be on frequent monitoring programmes for temperature, pulse, respiration and blood pressure. All others had routine monthly recordings of these observations and the care plans reviewed demonstrated that this was maintained. People had their weight monitored monthly and more often if required. The registered nurse explained that weight loss was always investigated. None of the care plans reviewed identified any significant weight loss. One person required urethral catheter care and had relevant risk assessments carried out prior to the insertion of the catheter by the GP. The care plan identified that the catheter bag was changed twice weekly and the catheter every 6-8 weeks, a member of staff explained the daily catheter care that was carried out and recorded including fluid intake and output. Professional support from the GP was sought on a regular basis and any advice was acted upon.

Staff were aware of people's health needs and called in the GP and other health professionals as required. Two GPs visited people during the inspection, although they regularly attended on a weekly basis they also attend if required. The deputy senior nurse had asked them to attend to two people who required their input. Referrals had been made to healthcare professionals such as dieticians, speech and language therapists, and physiotherapists and their recommendations had been included in the care plans. On the day of inspection a nurse specialist in Parkinson's had attended to review two people that staff had concerns about. A specialist in "slips , trips and falls" had provided a training session for staff the day prior to inspection and the registered nurse was about to introduce an additional risk tool to identify when service users were more prone to falls.

People with pressure ulcers were cared for in general accordance with NICE Guidance. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. Pressure Ulcers are graded according to a number of factors but in particular depth and size, grade three and above pressure ulcers are reported as an incident. Professional support from a Tissue Viability Nurse (TVN) was sought for people with a pressure ulcer grade three and above. There was one person with a pressure ulcer identified on the day of inspection. This person had been admitted with a grade four pressure ulcer and with the support of the Tissue Viability Nurse the pressure ulcer had almost healed. Records for the needs of this person requiring full nursing care, admitted with a grade four pressure ulcer, identified contact and a visits from the TVN since admission. Body maps, photos and charts recording progress over time were completed. Improvement to the pressure ulcer could be demonstrated so that the support of the TVN would soon no longer be required.

On the day of inspection call bells were answered without any undue delay. We spoke with the manager and provider on how they monitored call bells and we were told that call bells were audited day and night and spot checks were carried out to ensure staff were attending to people's needs in sufficient time.

Recruitment procedures were in place to ensure staff were suitable for the role. This included the required checks of criminal records, work history and previous work references to assess their suitability for the role. A new member of staff in the nursing team confirmed this was the process they had undertaken before working at the home. The provider also ensured checks for agency staff. This ensured safe recruitment procedures were in place to safeguard people.

People were supported to receive their medicines safely. Policies and procedures had been drawn up by the provider for staff to follow to ensure medication was managed and administered safely.

Medicine administration was carried out by registered nurses who were designated competent to do so. Registered nurses had undertaken medicines competencies. These competencies were carried out 6 monthly. It was contained within a medicine folder kept in

Requires improvement

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the nurse's office within each unit. The competency document examined the nurses understanding of the medicine policy, procedures and knowledge of medication side effects.

All medicines were stored securely in a locked clinical room and appropriate arrangements were in place in relation to administering and recording of prescribed medicine. Medicines were administered four times a day and also as required. We observed medicines being administered at lunchtime by an agency registered general nurse who demonstrated that staff took care to ensure that the correct medicine was administered to the correct person. The nurse had worked at the home for two weeks and was familiar with some people however they checked identity with care staff to ensure they had the correct person. Each medicine record had a photograph of the person it applied to, supporting staff such as agency staff who may not have been familiar with the person. The nurse explained that any refusal of medication would be documented and re administered following discussion with other staff on the most appropriate way forward. No covert medicines were observed to be administered during this observation however the deputy senior nurse explained that there were people who had had their mental capacity assessed, a best interest meeting and had a management plan within their care plan to ensure they received their medication. The nurse administering medicines was interrupted on occasions although this did not have any obvious impact on people receiving their medicine's correctly

We observed the afternoon handover which was led by the registered nurse. There was a recently revised handover tool in place identifying concerns such as people who wished not to be resuscitation (DNAR) which was identified in red ink. The care staff gave an update on the status of the people they cared for. The nurse asked care staff to ensure that people who were not eating sufficiently were given fresh fruit juice rather than squash as the juice had more nutrients. Another carer reported on a person refusing food at lunchtime. The nurse agreed to assess the person's food intake and explained that they would arrange for a visit to the dietician if required. Staff also gave updates on progress with wound care and dressings. Another reported a person who had engaged in behaviours that were challenging, the nurse suggested initiating a behavioural risk assessment and a review of their care plan. This ensured that staff were communicated to and updated on people's wellbeing which also helped to ensure the correct care was being given.

Staff interactions were observed to be caring towards the people and demonstrated respect for their privacy and dignity. However we did observe some staff had difficulty with speaking good English and therefore could find it difficult to explain some of the day to day tasks they performed. We discussed this with the provider who told us "We have looked into support for the staff where English is not their first language. We have just employed an English teacher who will provide lessons for staff on a weekly basis".

Based on the evidence seen we have revised the rating for this key question to 'Requires Improvement'.

Good

Is the service effective?

Our findings

People and their relatives felt that staff were sufficiently skilled to meet the needs of people and spoke positively about the care and support. One person told us "They are pretty good at getting people out quickly if you have a problem that needs sorting". A relative also confirmed their loved one had access to the services they required, and they were always kept informed of appointments. Another relative said "They have their finger on the pulse and when my relative needs a doctor they respond on the day and always give me a ring just to keep me in the loop". The local authority were also supporting the provider and staff at the service by providing additional staff each day who gave support and expertise.

Care staff had knowledge and understanding of the Mental Capacity Act (MCA) because they had received training in this area. People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as required to make a decision in their 'best interest' as required by the Mental Capacity Act 2005. A best interest meeting considers both the current and future interests of the person who lacks capacity, and decides which course of action will best meet their needs and keep them safe.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. We found that the provider and the manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Staff records showed staff were up to date with their essential training in topics such as moving and handling and safeguarding. The manager told us they had recently increased moving and handling training to ensure staff were up to date with best practice. We were also told there were three staff members who were trained moving and handling trainers. The registered manager told us how they ensured staff were up to date and skilled in their role and how they were implementing more training in specialist areas for the staff such as a course on common health conditions and clinical training for nurses. Staff were knowledgeable and skilled in their role and meant people were cared for from skilled staff who met their care needs. One member of staff told us "There is always training scheduled very month. I recently completed a refresher course on moving and handling and found this it informative and helps me ensure I am doing everything correctly". We spoke with the deputy care manager who was responsible for the training and told us how they are looking to increase courses in key areas to ensure all staff are covered. Staff had also received one to one supervision meetings with their manager. Nursing staff were provided with clinical supervision and told us they worked closely with their manager for guidance and support.

The deputy care manager told us how they were working with the provider on introducing the new Skills for Care care certificate for staff and incorporating it into their induction and training. The certificate sets the standard for health care support workers and adult social care workers and will develop and demonstrate key skills, knowledge, values and behaviours to enable staff to provide high quality care. Eighteen members of staff were also going through the process of registering for a diploma in health and social care which also incorporated key skills in literacy and numeracy.

We spoke with people about the food and drink they received. One told us "Oh yes the food is nice, always something to choose from". Another person told us "The chef is very good we have lovely meals". A weekly menu was displayed in the hallway and people's orders were obtained on a one to one basis. The deputy care manager showed us pictures cards that were used for people who required assistance in choosing what they would like. The majority of people we observed were able to eat and drink unsupported. Where people required support both staff and relatives visiting were involved in this. Staff from other areas within the home helped people during lunch; this ensured that everyone was supported during their meal. Some people ate in the dining room others had lunch in the various lounges and there were a number of people who preferred to eat in their bedroom or who were bed bound.

Good

Is the service effective?

A staff member explained that if concerns were identified regarding weight, nutrition and diet then the person would be referred to a dietician. If someone had difficulty with eating solids the dietician could suggest a puree or liquid diet. The chef was able to explain the light and pureed diets available. Some people were encouraged to make cakes and biscuits for snacks and this took place in the dining room with support of the kitchen and activity staff.

People received support from specialised healthcare professionals when required, such as a dietician. For example, on the day of the inspection the dietician was in the service giving specialised advice on fluid intake and fluid balance. We observed them detailing an updated plan of action about fluids. They stated that they wanted the people to have other choices of fluid than cordials or squash, and to introduce fizzy drinks, milkshakes and personal choices. It was also clearly stated that "staff should be recording if people are offered a drink but refuse". The dietician wanted this course of action carried out with immediate effect. We observed that this information was highlighted and was passed across to staff at the next staff handover. We spoke with the manager who told us they had recently introduced milkshakes for people in the morning and afternoon. Incorporating high-calorie beverages in a daily routine can help ensure weight gain for older people. Access was also provided to more specialist services, such as a consultant psychiatrist and music therapy to assist with management of anxiety. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals.

We observed that the atmosphere in the service was calm and relaxed and staff supported people in an inclusive way and saw staff interacting with people in a calm and meaningful way. For example, we observed a staff member helping a person with a hot drink in their room, the interaction was not rushed and the member of staff was taking time to reassure and check that the person was ok and after receiving tea the staff member asked if they would they like a cold drink. Upon leaving the room the member of ensured a drink and call bell were within reach.