Macneil Limited

Ashton Lodge Care Home

Inspection Report

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Summary of findings

Overall summary

Ashton Lodge Care Home provides accommodation for up to 92 people who require nursing, personal care and support. The home is able to support people with physical disabilities, sensory impairments, and dementia. The home specialises in care for people over 65 years of age. At the time of our inspection 84 people were using the service.

People who used the service and their relatives were happy with the service received. Staff treated people kindly and with compassion. Staff were aware of people's likes, interests and preferences, and their care and support needs. The relatives we spoke with told us staff kept them informed of people's progress and any changes in their health.

Staff felt well supported by their manager. The team worked together and colleagues supported each other. Staff felt the manager was accessible, approachable and provided good leadership.

A manager had been recently appointed. They had submitted an application to become the service's registered manager and it was in the process of being reviewed at the time of drafting this report.

In general, people felt safe at the service. Staff were knowledgeable in recognising signs of potential abuse and concerns were appropriately reported. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

Risk assessments and care plans were in place. However, we found that many of them lacked detail and there were some inaccuracies in the information recorded in people's care records, particularly around pressure ulcer care, continence care and monitoring of food and fluid intake. This meant we could not be assured that care was always tailored to people's individual needs and that preventative measures were put in place to protect people's welfare and safety.

There was a lack of stimulation and activities on offer at the service. The activities that were on offer were not always tailored to people's interests and there was a risk that people may become socially isolated. Activities were mainly task based and there was little interaction between staff and people who used the service outside of this. We found at times people were not treated with dignity and respect, during mealtimes and toileting.

Systems were in place to monitor and assess the quality of service provision. However, we were unable to evidence that appropriate action was taken in response to areas identified as requiring improvement through these systems.

The problems we found breached health and social care regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures to the local authority.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements. Staff had followed relevant application processes and any conditions made by a Supervisory Body.

There were safe staffing levels in place. The majority of people and staff felt there were enough staff available to support people and respond to their needs, however some people felt there were delays in receiving the support they required.

Risk assessments were undertaken to establish any risks presented to people who used the service however, we found that management plans were not always in place to minimise these risks. We also found that prevention plans weren't always available, for example to prevent the reoccurrence of pressure ulcers. People were not always kept safe and their welfare was not always maintained. This meant there had been a breach of the relevant regulation (Regulation 9 (1) (b) (ii)) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

Assessments were undertaken to identify people's needs and these were used to develop care plans for people who used the service. We heard that changes in people's health were monitored and reported, when appropriate, to family members. However, we found that some people's care records were inaccurate and did not contain sufficient detail. For example, one person was incontinent but there was not sufficient information in their care plan about how to meet their continence needs. This meant people were at risk of not receiving care in line with their needs.

People were provided with a choice of food and drink at mealtimes and throughout the day. However, we found that people who were at risk of dehydration or malnutrition did not always have their food and fluid intake accurately recorded. This meant there was a risk that the person may become dehydrated without staff being aware. We found there had been a breach of the relevant regulations (Regulation 9 (1) (b) (i) and 20 (1) (a)) and the action we have asked the provider to take can be found at the back of this report.

Staff were skilled and experienced, and received regular training.

Summary of findings

Are services caring?

We observed some staff interacting with people who used the service and they treated them kindly and with compassion. Staff were conscious to maintain a person's privacy. Staff were knowledgeable of people's needs and their likes, interests and preferences. However, we observed that at times people were not always treated with dignity and respect. For example, we observed staff talking about people in front of them as if they were not there and in a language that people were not able to understand. We found there had been a breach of the relevant regulation (Regulation 17 (1) (a) (2) (a)) and the action we have asked the provider to take can be found at the back of this report.

Are services responsive to people's needs?

People's capacity was assessed where appropriate, to establish whether they were able to make decisions about their care, and what areas of their care. For example, we saw that some people's records stated they could make day to day decisions but were unable to make decisions about their care and treatment. When people did not have the capacity to make decisions, best interest decisions were made by the staff at the service together with the person's next of kin.

We observed that there were a lack of activities and stimulation available. We saw that whilst interactions with staff were caring these were mainly task orientated and did not always take people's preferences into account. Some people felt activities were not tailored to their interests and we found that some people were at risk of becoming socially excluded. This meant there had been a breach of the relevant regulation (Regulation 17 (2) (g) (h)) and the action we have asked the provider to take can be found at the back of this report.

People felt able to raise concerns and make complaints and that these would be dealt with appropriately. People told us about concerns they had raised with the manager previously and that they had been addressed.

Are services well-led?

Staff felt there was good leadership within the team and felt the manager was accessible and approachable. Staff felt their views and opinions were listened to. They felt supported by the manager and their colleagues.

There were processes in place to review any incidents and complaints, and these were appropriately investigated. Systems were in place to monitor the quality of the service. However, we noted that actions identified in a contract monitoring visit in

Summary of findings

February 2014 by the local authority and from a night visit undertaken by the manager had not been addressed across the service at the time of our inspection. This meant there was a breach of the relevant regulation (Regulation 10 (2) (c)) and the action we have asked the provider to take can be found at the back of this report.

Summary of findings

What people who use the service and those that matter to them say

Generally people who used the service and their relatives were happy with the service they received. They told us they felt safe, although some had concerns about what would happen if they had a fall.

People told us they liked the staff at the service, and that "the carers are nice, you can talk freely to them." Visitors said staff were aware of their relatives' needs and provided them with support in a way they liked. One person told us, "they're [the staff] very caring." Another person said, "they encourage me to help myself." However, one person felt that staff were not always available when they needed them and told us, "I shouldn't have to ask for help, they should help me."

Visitors felt their relatives were well looked after, and always looked clean and well presented.

People and their relatives felt well informed and involved in decisions about their care. They told us they felt listened to and were aware of the information included in their care plans.

There were differing opinions from people about the activities on offer. Whilst some people felt there were lots of activities available, one person told us, "there's no activities whatsoever."

People and their relatives felt able to ask staff questions and inform them if they had any concerns. They told us any concerns they had raised had been quickly addressed.

Ashton Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process.

Before the inspection we reviewed the information we held about the service, including the findings from the previous inspection in February 2014. At that inspection the service was meeting the regulations assessed.

We visited the home unannounced on 24 April 2014. The inspection team consisted of a lead inspector, a specialist advisor who is a qualified nurse and has experience of supporting people with dementia, and an expert by experience who has experience supporting family members with their health and social care needs. The team was joined by a member of the Care Quality Commission's design team who was evaluating the new methodology.

During the inspection we spent time talking with people living in the home, their relatives, the manager of the service, nurses and care staff. We observed care in two dining rooms at lunchtime and three lounge areas. We undertook general observations and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us. We looked at all communal parts of the home and some people's bedrooms, with their agreement.

We spoke with 16 residents, six relatives, eight staff and the manager of the service. We looked at 12 people's care records and records relating to the management of the home.

We asked the provider to send us further information relating to quality assurance processes which they did the day after the inspection.

We also spoke to a range of health and social care professionals who visited the service, including the visiting GP, a member of the palliative care team and a member of the contract monitoring team from the local authority.

Are services safe?

Our findings

People who used the service told us they felt safe staying at the home.

However, we found that appropriate procedures were not in place to ensure people's safety and welfare. This meant there had been a breach of the relevant legal regulation (Regulation 9 (1) (b) (ii)) and the action we have asked the provider to take can be found at the back of this report.

Risk assessments were undertaken for each person that used the service to identify whether people were at risk of developing pressure ulcers, falling or becoming malnourished. However, many of the assessments lacked detail on how to manage the risks identified. We saw that for people who were at risk of developing pressure ulcers their care records lacked information about how to prevent the pressure ulcer developing, for example, the frequency that people should be repositioned. One person had, at the time of our inspection, a grade two pressure ulcer but there was no care plan in place in regards to the care of this ulcer. There were no records monitoring the development or breakdown of the ulcer. This meant that staff were not able to monitor the progress of the ulcer and there was a risk that the appropriate care may not be received. We saw that another person was sitting in the sling from their hoist. They told us the reason for this was, "it's easier for staff to leave it." This put the person at risk of skin damage.

One person had swallowing difficulties and was at risk of choking. This person's care plan stated staff were to monitor signs of aspiration but did not provide sufficient guidance about what to do if these signs occurred. This meant there was a risk that people would not receive effective medical treatment in a timely manner.

In records viewed we saw information regarding healed pressure ulcers had been archived and preventative plans were not adequate. This meant staff were not always aware from the records who had previously had a pressure ulcer and were therefore at high risk of developing further sores. Two people's moving and handling risk assessments stated they required the use of a hoist but there was no information for staff about how to safely hoist the person. This meant they were at potential risk of unsafe moving and handling.

Staff kept people protected from avoidable harm from other people who used the service. We observed staff dealt effectively with a situation that saw one person display challenging and aggressive behaviour towards another person using the service. Staff were quick to calm people down and diffuse the situation. We also observed staff being patient and non-confrontational with people who were aggressive towards them.

Staff were knowledgeable in recognising signs of potential abuse and were aware of the reporting procedures. We saw the service liaised effectively with the local authority's safeguarding team and notified us as required of any safeguarding concerns.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements. Staff had properly followed relevant application processes and any conditions made by a Supervisory Body. Staff had received training in the Mental Capacity Act 2005.

During our inspection one person was on one to one support from a staff member to ensure the safety of the person and other people using the service. The staffing numbers had been increased to accommodate this additional need. Staff spoken with felt there were enough staff to enable them to look after people who used the service and meet their support needs. Staff told us cover was arranged if a member of the team was on leave or off sick.

The majority of people we spoke with told us they felt there were enough staff around, however, some people who used the service felt that there were not always enough staff available. One person told us, "I don't get enough help" and "I shouldn't have to ask for help, they should help me." Another person told us, "it takes longer now for someone to come." During the inspection we observed staff responding promptly to people's needs and answering people's call bells quickly.

Are services effective?

(for example, treatment is effective)

Our findings

Care plans were developed identifying people's care and support needs. These were based on information gathered through undertaking life histories with people, the pre-admission assessment process and talking with their relatives. This information was used to identify how people wished to be supported, what areas of their care they could do for themselves and where they required support from staff.

However, we found that inaccuracies and missing information in care plans and records meant that people were at risk of not receiving care and treatment in line with their individual needs, and that appropriate preventative measures were not in place to maintain a person's health and welfare. This meant there had been a breach of the relevant legal regulation (Regulation 9 (1) (b) (i)) and the action we have asked the provider to take can be found at the back of this report.

One person's continence care plan stated they required being toileted regularly, but there was no guidance about what regularly meant or about how frequently their pad should be changed. We saw from one person's care plan that they could tell staff when they needed changing. However, there were no plans in place to promote continence. This meant people were not able to maintain their dignity in regards to their continence care. Another person had a catheter but there was no catheter care plan in place. We could not be assured that the person was receiving their appropriate catheter care.

One person had recently been discharged from the hospital with a urinary tract infection. There was no care plan in place regarding the infection nor was there a plan to prevent an infection developing in the future.

Three people whose records we reviewed were diabetic but there was a lack of information available about what diets these people received and we could not find evidence that this was reviewed in line with their blood glucose levels. This meant people were at risk of not receiving appropriate diabetic care.

People were weighed monthly or more regularly if there were concerns that they were losing weight. However, we saw that in one person's records they had lost 4kg between their last two weighings, and there was no reference as to what action was taken in response to this. This meant people were at risk of unplanned weight loss without staff acting upon it.

We also found that whilst some people were receiving the appropriate care an accurate record of their care needs were not kept. This meant there had been a breach of the relevant legal regulation (Regulation 20 (1) (a)) and the action we have asked the provider to take can be found at the back of this report.

We noted that food and fluid charts were not accurately completed. For example, we saw that one person's care plan review stated that "food and fluid intake was good" and they had gained 1kg in the last month. However, when we reviewed their fluid charts it was frequently recorded that they were not meeting their recommended intake. This meant that for people at risk of dehydration staff were not able to accurately review the amount of fluid they had received.

We found that some people's care records were not updated as their needs changed. For example, one person's mobility needs had changed but this had not been reflected in their care records. This meant there was a risk that people did not receive care to meet their current needs as their health either improved or deteriorated throughout their time at the service.

Life histories were undertaken for people who used the service so staff were able to get to know them, their families and their interests, likes and preferred daily routine. People's individual needs regarding food preferences were communicated with the kitchen as part of the admission process.

There were signs in each dining area reminding people that hot drinks and snacks were available throughout the day. Cold drinks were made available to people and we saw that each person had a jug of their preferred drink in their rooms. People were regularly being asked if they wanted a drink. We observed that during lunchtime on the second floor that staff took 20 minutes to notice that one person required assistance. We observed that staff were busy supporting those people who were unable to feed themselves, which meant people that were more capable but still required some support and encouragement from staff were not able to receive this in a timely manner.

Are services effective?

(for example, treatment is effective)

Induction programmes were in place to support new staff. This included three days with one to one support from a more experienced member of staff. During our inspection we saw that a new nurse was being supported by the deputy manager. We spoke with some members of staff who had been recently promoted. They felt supported in making the transition to a senior role.

A rolling programme of training was available for staff to access to increase their knowledge and skills. We reviewed the training records for staff and it showed that 70% of staff were up to date with their mandatory training and where refresher courses were due this had been identified and booked. Staff had also been able to attend additional training to increase their knowledge and skills to further support people who used the service. This included training on supporting people with challenging behaviour, dementia care awareness, dignity in care and end of life care.

Staff were provided with supervision every two months. We saw from records and speaking with staff that supervision sessions were held more frequently if staff required additional support, one to one training or to address any concerns in performance. Staff told us there was a process in place to peer review each other's performance and they found this a good way of sharing skills and knowledge throughout the staff team.

Are services caring?

Our findings

We found that at times people were not treated as individuals and were not always treated with respect or able to maintain their dignity. This meant there had been a breach of the relevant legal regulation (Regulation 17 (1) (a) (2) (a)) and the action we have asked the provider to take can be found at the back of this report.

Whilst the interactions we observed were caring they were largely task based. There was very little social interaction observed between staff and people who used the service. We observed on the third floor that staff ignored a person talking to them and continued with their task. We also observed one staff member moving a chair a person was sitting in without explanation to the person why that was required. Some staff spoke to us in front of people as if they were not there. We also observed staff talking to each other in their mother tongue that was not English which meant that some people were not able to understand what they were saying.

Our observations at lunchtime on the first floor identified that people were not being adequately supported to eat their meals. One person required one to one support from staff. The staff member was not sitting at the same level as the person and held the plate so the person was unable to see what was on it. The staff held the next fork full of food next to the person's mouth before the person had finished their previous mouthful which could lead to people feeling rushed to finish their meals. During this meal there was little interaction between the staff member and the person they were supporting. This meant that at times people were not treated with respect or able to maintain their dignity during meal times. However, we observed lunch on the second floor where staff were supporting those that required it. Staff were patient and polite, and supported people at the pace set by the individual. People were given choice about what they liked to eat and whether they wanted dessert, tea, or coffee.

We observed staff pushing a person in a wheelchair. The person's foot was not centrally placed on the footrest of their wheelchair. The staff member accidentally wheeled the person hitting their foot against a door frame. They repositioned the person's foot on the rest appropriately, but did not apologise or ask the person if they were ok.

People who used the service and their relatives told us they found staff to be kind and caring. One relative told us, "Mum and I come every day and I can honestly say I cannot fault the staff. There always seems to be plenty of staff around and you only have to ask for something and they do it. They are all very kind people." We observed that staff had a good relationship with people who used the service and their relatives, and were keen to meet people's needs.

Staff were aware of the importance of maintaining people's privacy, especially whilst having their personal care needs met. Staff took care to ensure people were well presented. One visitor told us the staff helped their relative to get changed if they spilt something down their top during meal times. Visitors told us their relatives were always clean, dressed well and had their hair brushed. One relative told us, "he always looks clean and well cared for, he would like that."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The delivery of care was not always able to meet people's individual needs in regards to activities, socialisation, and religious needs. We found there had been a breach of the relevant legal regulation (Regulation 17 (2) (g) (h)) and the action we have asked the provider to take can be found at the back of this report.

One person told us, "there's no activities whatsoever." Another person told us, "it's difficult for those with active minds, there's not enough people to talk to."

We observed on the first floor that one staff member attempted to engage in an activity with one person in the lounge. The other people in the lounge were sat around doing nothing and there was no stimulation provided. There was a mixed response from people about opportunities to build and maintain friendships at the home. One person told us staff had supported them to maintain friendships with other people at the home. However, they also told us they used to have a group of people within the home that got together to play dominos, but that this had been stopped. We could not find evidence of stimulation being provided to people who were confined to their bed throughout the day.

We observed that people were not asked what they would like to watch on the TV or listen to on the radio in the lounge. We asked a person who was watching the TV who chose the channel and they said they didn't know but that they didn't know where the remote was to be able to change channels.

The home had a multi-faith room and some religious representatives attended to meet people's religious needs. However, the home was not currently able to support people to practice all religions. We observed staff playing music and singing songs in the communal areas but the songs chosen were aimed at people of Christian faith. People in the room told us they were either not Christian or preferred not to practice a religion. They told us, "I don't like all this religious stuff that is why I do not go to church."

Staff informed us they spoke with people or their relatives to get their views on how they wished to be supported and cared for. One relative we spoke with told us the staff kept them informed of any changes in their relative's health or support needs, and provided them with copies of care plans and asked for their agreement with the plans in place.

Where people required additional support to make decisions the service had access to an independent mental capacity advocate. Assessments were undertaken on admission to establish whether people had the capacity to make decisions and what aspects of their life they were able to make decisions about. For example, we saw that some people were able to make day to day decisions but did not have the capacity to make decisions about their health or end of life care. Where people did not have the capacity to make decisions the service liaised with the person's next of kin and made decisions within the best interests of the person using the service. It was clear in the care records we reviewed who was to be involved in making decisions on behalf of the person using the service if they were unable to make those decisions themselves.

Staff kept people informed about hospital and other healthcare appointments. We observed one person asking for a copy of a letter about an upcoming appointment and this was provided to them.

Advanced care plans were available for most people which included information about their end of life choices. However, we saw that one person's advanced care plan stated they had chosen not to be resuscitated but there was no DNACPR form available. This meant there was a risk that people would be resuscitated against their wishes.

People felt able to raise concerns and complaints. Two people we spoke with told us they had raised concerns with the manager and they found them to be accessible and responsive to their needs. For example, one person had complained the food arrived cold to the dining room and the manager had liaised with the kitchen staff to address this. Another person mentioned that the grass in the back garden needed cutting and weeding and a few days later this was done. A relative we spoke with told us, "the manager is really good she is always around and the staff seem to respect her. I think if I had a complaint to make she would take it seriously and fix whatever was wrong really quickly."

There were regular residents meetings that gave people the opportunity to comment on the service provided. Any

Are services responsive to people's needs?

(for example, to feedback?)

actions arising from the meetings were discussed during the following meeting to establish if they had been addressed. Relatives meetings were also held. One relative told us, "the meetings give us an opportunity to discuss and identify any concerns – they are always quickly addressed."

Are services well-led?

Our findings

At the time of our inspection the provider did not have a registered manager. However, a new manager was in post and they had applied for registration with the CQC before our visit. They demonstrated good leadership at the service and were in the process of implementing changes to improve service delivery.

There were processes in place to assess and monitor the quality of service provision and we saw the findings from a range of audits undertaken. However we found that appropriate actions had not been taken in response to areas identified as requiring improvement. This meant there was a breach of the relevant regulation (Regulation 10 (2) (c)) and the action we have asked the provider to take can be found at the back of this report.

We saw that internal medication audits were undertaken as well as external audits from the local pharmacy. Health and safety audits, including fire risk assessments and infection control audits were completed. The home manager undertook night visits to assess the quality of service provision outside of normal working hours. The assessments we saw showed ongoing concerns regarding inaccurate recording on fluid charts which had not been addressed at the time of our inspection. We also saw the findings from a visit from the local authority in February 2014 which identified gaps in care plans and risk assessments and we found there was still missing information in care records at the time of our inspection. This meant at times areas identified as requiring improvement were not actioned across the service and the service did not always provide continuous improvement in the quality of information in people's care records.

Staff told us the manager was, "very supportive, especially when you are new." Staff felt there were people around to ask for advice or further support. The manager had an "open door" and staff felt the manager was accessible and approachable, and provided good leadership at the service.

Staff meetings were held regularly and gave staff the opportunity to discuss service delivery. Staff told us, "it's an open forum" and they were all able to request items to be put on the agenda and be discussed.

Staff told us there was good morale within the staff team and everyone worked well together. Staff said, "there's great team work – everyone helps out." They said they felt able to admit if they made a mistake and staff supported them to improve their practice and reduce the chance of mistakes happening in the future. Staff told us, "if anything needs improving we do this on an ongoing basis."

There were processes in place for the team to review and learn from incidents and complaints. Each month the manager of the service analysed the incidents that occurred and the complaints received to see if there were any trends and to identify learning. We reviewed the last four months of incidents. The analysis of the incidents identified the types of incident, the times the incident occurred and the action taken, this included identifying additional training that staff benefitted from. The analysis also identified when the incidents were of concern and a safeguarding referral had been made.

We reviewed all complaints received in the last five months. We saw that complaints had been investigated and responded to accordingly. If staff were mentioned in a complaint the manager undertook additional supervision sessions to address the concerns identified. People who used the service and their family members were provided with feedback about the action taken in response to their complaints. We saw that feedback was provided to other health professionals if they raised any concerns and their feedback was sought to establish if they were satisfied with the improvements and action taken.

Any clinical concerns and complaints were discussed during staff meetings to discuss the progress of investigations and to disseminate information amongst the staff team.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare The registered person did not take proper steps to ensure that the planning and delivery of care met service user's individual needs and ensured their safety and welfare. (Regulation 9 (1) (b) (i) (ii))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not protect service users against the risks of inappropriate or unsafe care by making changes to the care and treatment provided. (Regulation 10 (2) (c))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users The registered person did not make suitable arrangements to ensure service users were treated with dignity, compassion and respect. They did not ensure service users were provided with opportunities to promote community involvement, and care was not always provided with regard to service user's religious persuasion. (Regulation 17 (1) (a) (2) (a) (g) (h))

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Accommodation for persons who require nursing or personal care

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010

Records

An accurate record of each service user was not kept and did not include appropriate information and documents in relation to the care and treatment provided. (Regulation 20 (1) (a)).