Bupa Care Homes (BNH) Limited

# Ashley House Care Home

## Inspection report

118 Trafalgar Road
Cirencester
Gloucestershire
GL7 2ED

Date of inspection visit:
18 May 2016
19 May 2016

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02 August 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This unannounced inspection took place on 18 and 19 May 2016.

Ashley House provides nursing, residential and respite care for up to 44 people. At the time of our inspection 37 people were living there. There was 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. There were no breaches of legal requirements at the last inspection in July 2014.

People told us they felt safe in the home. Staff knew how to keep people safe and were trained to report any concerns. Sometimes people had to wait for staff to answer their call bell. Recent changes in deployment of staff were aimed to help improve the experience for people. People were supported by staff that were well trained and had access to training to develop their knowledge.

People were provided with personalised care and were supported to make their own choices and decisions where possible. Staff knew what they valued and how they liked to be supported. Peoples care was regularly reviewed and any specific care needs were recorded and evaluated to record progress. People were usually treated with kindness and compassion and people told us staff were very good when they supported them with their care. Healthcare professionals supported people and there was good care and support for people and their relatives when nearing the end of their life.

People told us the food was good and there was a choice of meals. When people required assistance with their food staff supported them and gave them time to enjoy their meal. Hot drinks were always available in the foyer for people to relax with their visitors. This area was due to be refurbished to enhance the experience for people.

People had activities to choose from which included quiz games, exercise classes, pat the dog, arts and crafts, musical afternoons and ball games. Care staff had helped to provide activities for people when there was no activity organiser but there had been less individual engagement with them. Volunteers visited the home and spent time talking to people. Improvements to activities were planned when the new activity organiser started soon.

The registered manager and provider monitored the quality of the service with regular checks and when necessary action was taken. People and their relative's views and concerns were taken seriously. They contributed in meetings and regular reviews of the service and improvements were made. Staff felt well supported by the registered manager and deputy manager who were available to speak to people their relatives and staff. Staff meetings were held and staff were able to contribute to the running of the home.

## 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**

This service was not always safe.

People's care and support needs were assessed to monitor the staffing levels required but people had to wait sometimes for staff to meet their needs.

People were safeguarded as staff were trained to recognise abuse and to report any abuse to the local authority safeguarding team.

People were protected by thorough recruitment practices.

People's medicines were managed for the most part safely to ensure people were receiving medicines correctly and staff were competent.

The home was clean and health and safety and fire risk assessments had been completed.

### Is the service effective?

**Good**

This service was effective.

Staff training was up to date. Individual and group supervision meetings were completed regularly to monitor staff progress and plan training.

People made decisions and choices about their care. Staff were confident when supporting people unable to make choices themselves, to make decisions in their best interests in line with the Mental Capacity Act 2005.

People had access to social and healthcare professionals and their health and welfare was monitored.

People's dietary requirements and food preferences were met for their well-being.

### Is the service caring?

**Good**

The service was caring.

Sometimes people had to wait for care and support.

People were treated with compassion and kindness.

People were treated with dignity and respect when they received end of life
care.

## Is the service responsive?

Good

The service was responsive.

People received the care and support they needed and were involved in decisions about their care.

People took part in activities and staff sometimes engaged with them individually but this could be improved.

Comments or concerns were investigated and responded to.

## Is the service well-led?

Good

The service was well led.

The quality checks completed included people and their relatives view of the service.

The manager was accessible to staff and people and planned improvements for the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

# Ashley House 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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 19 May 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert had experience in supporting people with mental health including older people living with dementia.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, deputy manager, three care staff, one nurse, a chef and the area operations manager. We spoke with eight people who use the service and six relatives. We looked at information in seven people's care records, three recruitment records, staff training information, the duty roster and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We also contacted healthcare professionals that visited the service to obtain their view of the service.

Requires Improvement

# Is the service safe?

## Our findings

Staff were not always deployed in a way that kept people safe. Three people and a relative told us they had to wait for staff to help them. A member of staff had told them, "see you in a bit" and another member of staff said "see you in a minute." One person told us they waited two hours to be helped after their breakfast on the day we visited. One relative told us call bells were usually answered on time during the day but not so much at night. One person told us, "Bells mostly answered but it would be nice to know the bell is acknowledged, but it isn't regularly." One person and their relative told us the staff were, "Excellent at answering the call bell". We asked the registered manager to check the call bell times to identify how long it had taken staff to answer them and 24 bells were answered in over six minutes. The registered manager told us this number may have been because staff activated the sensor in three people's bedrooms which sounds the call bell when they entered. The following day at the same time there were four genuine call bells recorded as answered over the six minutes which excluded any sensor activation.

People's dignity was not always respected by staff when there was a delay in answering their call bell. One person told us, "Some carers don't care", as their bell was not answered soon enough. They also told us messages for the nurses do not get passed to them and they felt "fobbed off". We asked the deputy manager to speak to this person about their concerns and they did. Recently the deployment of staff had meant staff answered a call bell on any floor. People's bedrooms were over three floors and the fourth floor was temporarily empty due to people moving there while their bedrooms were soon to be refurbished. A relative told us staff had taken a long time to answer the call bell, however they said this was "improving". There may be an impact for people when staff are deployed to cover all four floors. The provider had already asked the registered manager to monitor the call bells to make sure people didn't wait too long and this was an on going review.

There were 37 people accommodated and their dependency scores were recorded on admission and evaluated annually. Weekly clinical review meetings may change people's dependency score which helped to calculate staffing levels. The registered manager told us there was no one at the highest dependency score and the service was over the staffing levels for people's current dependency. We looked at copies of the staff rotas and discussed the deployment of staff with the registered manager. The registered manager told us they took the layout of the home into consideration when calculating the number of staff required and the deployment of staff was decided by the member of staff in charge of the shift. Two staff told us people had to wait sometimes for their call bell to be answered when they were short staffed due to sickness. The registered manager told us staff sickness was usually covered by their own 'bank' staff or agency staff they had used regularly. Sometimes staff worked additional shifts and there were times when peoples planned admissions were expected and additional staff were on duty. On the second day of the inspection visit additional staff were on duty because the lift was being serviced and people needed more support upstairs.

People told us they felt safe in the home. Staff understood their safeguarding responsibilities and completed annual safeguarding training. Staff explained what they would do to safeguard people by reporting any incidents to the registered manager or the local authority safeguarding team. Staff were aware of the

services 'Speak Up' policy where they could tell the provider directly about concerns and be protected. There were safeguarding policies and procedures for staff to follow when abuse was witnessed or suspected. Records indicated the correct action was taken when required.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. One person who had a history of falls was referred to the GP and fall clinic. The service installed a series of hand rails leading to and from the person's bedroom which the physiotherapist had recommended.

Risk assessments were in place to support people to be as independent as possible. We found risk assessments in place for people falling, their nutrition, how to move them and for risk of skin breakdown. Guides to the level of risk were recorded to ensure the correct action would be taken. Health and safety risk assessments were completed for the service which included all areas and fire risk assessments. These were regularity updated to ensure any actions were completed to prevent hazards.

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and were of good character. Two or three references were held for each staff member which included their most recent employer. All appropriate checks were completed and people living in the home were included in staff interviews as their opinion was valued. One person told they had been part of a staff interview and they had been "suitable".

There were mostly safe medicine administration systems in place and people received their medicines when required. However we noted unsafe practice where one person was self-medicating. When we highlighted this issue the service changed the procedure quickly to ensure safe storage and correct administration. A spot check of two medicines on the day of the inspection was incorrect as medicine amounts were not carried forward from the previous month. A recent improved medicine administration record meant all medicines would be carried forward and accounted for. This ensured a correct count of medicines could be achieved to monitor administration was complete. There was recorded guidance when people had their medicine 'as required' to make sure all staff made the correct decision. Any medicine given 'as required' was recorded in both the administration record and the persons care plan.

A ten point check was completed by staff during each medicine round to monitor staff competency. There were body charts to indicate where and how much cream staff should administer to peoples skin. Staff had an annual medicine administration competency check to ensure their practice was safe. GP's completed medicine reviews six monthly. The temperature of the storage rooms and fridges were monitored to ensure they were correct.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed contingency plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

There were infection control procedures for staff to follow and they completed training to ensure they were updated with the latest guidance to prevent cross infection. We observed staff using personal protective equipment, for example plastic aprons and gloves, to promote infection control. The home was clean and there was a major refurbishment due to update ensuite facilities and communal areas.

Good

# Is the service effective?

## Our findings

People's rights were protected because the staff acted in accordance with the Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported to make their own choices and decisions where possible. Where people lacked the capacity to make some decisions the registered manager had followed mental capacity assessment procedures and completed a best interest decision record. An example we looked at for a 'best interest' decision was a person that required the use of bedrails as they had fallen from a low bed. Their family had been involved in the decision process. Although the person could make some everyday choices they were unable to understand the need to use the bedrails for their own safety. Most staff had a good understanding about the principles of the Mental Capacity Act 2005 (MCA) but additional MCA training was planned.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. An example seen was one person was at risk from their bedroom being upstairs. The 'best interest' and least restrictive decision was to relocate their bedroom on the ground floor. The conditions for the DoLS authority were set out and were reviewed as being successful for the person. The authorisation expired in December 2016 and the registered manager was aware of the need to reapply. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us their training was up to date. One nurse told us they had just completed an end of life training day and their wound care knowledge was updated regularly with clinical information booklets. They told us they had completed medicine competency training and face to face MCA training was planned.

A programme of training to maintain and update staff knowledge and skills was in place and staff were informed when their training was due. Staff had completed a range of training to include dignity and respect, health and safety, moving and handling, infection control, fire safety and food hygiene. The deputy manager trained staff and completed their induction training to include moving and handling and informed us some staff required an update to this training. New staff had started the Care Certificate. The Care Certificate lays down a framework of training and support which staff can receive. Essential dementia care training was included in staff induction training.

Five care staff were currently completing the new Qualification and Credit Framework (QCF) level two in health and social care. It recognises qualification and units and awards learning credits. One care staff member told us they were completing NVQ level three in health and social care and felt well supported by

the deputy manager who maintained a good standard for staff to follow. One person told us they felt staff were well trained.

Specialist dementia care training was planned for all staff. Nurses were completing Percutaneous Endoscopic Gastrostomy (PEG) feed training. A PEG tube enables liquid food to be given through a tube to the stomach. The registered manager told us there had been good results from the nurses' reflective practice training towards their professional development and revalidation, which he had completed with them. End of life and tissue viability training for the nurses was planned. The provider information return told us 30 care staff had completed the NVQ level two or equivalent in health and social care. Clinical practice training for nurses with a set of competencies for Registered Nurses was being developed and started in 2016. One nurse had volunteered to complete a NHS training 'Recognising the Sick and Deteriorating Patient'. The registered manager and one nurse were going to be trained as mentors for a student nurse on placement from Oxford Brookes university.

People were supported by staff that had individual supervision meetings and appraisals. The records identified three staff that had not completed individual supervision although staff meetings were used as general supervision for all staff. Two staff told us they had not had regular individual supervisions but the dementia training they both wanted was planned. Both staff told us they were well supported by the deputy and registered managers.

People's dietary needs and preferences were recorded. Catering staff met people when they arrived and regularly checked they had what they wanted The chef had a good understanding of people's dietary needs and kept a record of their likes and dislikes. A weekly list was given to the chef of people's diets and weights to ensure people had the correct diet and fortified food if they were at risk of malnutrition. The chef attended the weekly clinical review where a nurse and the managers discussed peoples care and their dietary needs. We observed a clinical review where people's dietary risks were discussed and the need for a nurse always being in the dining room when people were at risk from choking.

People were referred to the dietician and speech and language therapist if staff had concerns about their wellbeing. There were 11catering staff and they had all completed a food hygiene course. The service had received the highest food safety award of five stars from the local council. People told us the food was, "good", "very good" and "lovely" and there was a choice of food and drink. People had the choice of water, soft drinks, wine and sherry with their meals. We observed people were assisted with their meals in a calm and unhurried manner. There were hot drinks available in the foyer at all times for people and their visitors and there were plans to develop this area further to enhance the experience for people to meet there.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist, an optician, a chiropodist and a psychiatrist. One person was supported by a dietician as they had lost weight and were monitored weekly. The dietician had been pleased with the person's progress of weight gain in a recent review.

Good

# Is the service caring?

## Our findings

People were usually treated with kindness and compassion they told us, "Staff are wonderful", "Most staff are delightful", "Staff are very good" and "They [staff] are all very nice." Relative told us, "There are good interactions between people and staff" and "staff are marvellous." One person told us the staff always rang their bedroom door bell before they were invited into their room and they were always kind. They told us they had a drawer they could lock for privacy and security. There were 23 'Everyday Hero' comments posted on a notice board in the last 12 months from people, relatives and staff and all were complimentary about staff being kind, considerate and helpful.

There were volunteers from a local school visiting people and talking to them which people appreciated and enjoyed. People were able to keep in touch with friends and relatives by phone when they liked. A relative told us the staff were caring and were "pretty good." Staff respectfully called people by the name they preferred. People's records included information about their personal circumstances and how they wished to be supported in a record called My Day, My Life, My portrait, which was regularly updated with recent changes. When people were having personal care a notice would be on the outside of their bedroom door to protect their privacy. We observed staff speaking to people and their relatives in a friendly and welcoming manner.

People's bedrooms were personalised and decorated to their taste. People had photographs of their family and friends and their own treasured possessions in the bedrooms. A staff member told us they will do peoples shopping for them as part of their keyworker role. People told us they had a keyworker. A key worker is a named member of staff that is responsible for ensuring people's care needs are met. This included supporting them with everything they needed and organising appointments and trips out for them.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. One person was supported with their end of life care and had requested that only female care staff look after them and their wishes had been respected. Their care plan contained information and recent changes to their care where pain control was required. There was clear guidance for staff and anticipatory pain control medicines were in place for the person when they required it. The GP and palliative care team were fully involved in the person's care and were consulted as necessary. Regular pain assessment and evaluation was recorded to ensure the person was comfortable and not feeling unwell.

There was a lot of accessible information for people on the Community Connections notice board which included local services available to people, for example Alzheimer's and eye care services.

Good

# Is the service responsive?

## Our findings

People had their needs assessed before they moved into the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. Care, treatment and support plans were personalised. The examples seen were thorough and identified people's needs and choices. An example was a person with some memory loss who liked to feel secure and called out to staff. There was clear guidance for staff about the person's preferences and a record of incidents when the person had been anxious and what had helped them.

Staff told us there were recent changes in care planning which had improved people's care records. One staff member told us the care plans were really helpful. They said the care plans detailed peoples care for example their individual moving and handling and continence care equipment was included. There were short term care plans when people were treated with antibiotics and it outlined what support they needed and when to notify the GP of any changes. Care plans were evaluated monthly with meaningful explanations. For example, one person's wound care plan was detailed and staff were able to recognise when the person was experiencing any pain. A photograph had been taken of the wound and the healing rate was recorded. The wound was recorded to be healing.

People had their position changed in accordance to their needs to prevent skin damage. People at risk from dehydration had a record of their fluid intake with a daily total to assess whether sufficient fluids were given. People told us, "Everything is excellent" and "I am very lucky to be in this home." A relative told us, "The respite care I had was very good" and "Mother is looked after."

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. During a handover a person's progress after physiotherapy was noted and medicine storage for a person self-medicating was discussed.

People had a programme of activities they could be involved in. These included quiz games, exercise classes, pat the dog, arts and crafts, musical afternoons and ball games. Activities were organised by the care staff during weekend afternoons. There had been no activity organiser for several weeks. Care staff had been given the role before the new activity organiser started the week after our visit. One relative told us, "There has been no activity officer and this has been the case over quite a few weeks, mother needs stimulation. There are no outings now in the minibus, these used to be arranged by the activity officer". Another relative didn't think staff engaged with the person enough. One person told us they met with people from the local church in the church hall. They told us a new activity organiser was starting and there would be a new list of guest speakers to provide interesting talks. The person told us they did exercise classes and went to residents meeting so they influenced things and suggested outings. They told us about a recent outing when a coach was hired and they went to the local garden centre.

The manager told us there was 25 hours allocated to activities currently but this will increase when the newly appointed full time activity organiser starts and has an assistant. There were less individual activities

for people currently but volunteers helped engage with people. We observed a quiz game in the lounge where two staff members were helping people. There was a good attendance and people looked as if they were enjoying the quiz. Trips out had included one to Lechlade in March and Wotton Bassett in April this year. People had also been on escorted walks to Cirencester town and the Abbey, hand bell ringers and an Elvis Presley impersonator had visited the home and there was an illustrated talk about local pub signs. Activities people had taken part in were not recorded.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. People knew how to complain and would speak to the registered manager first. There had been three complaints in the last 12 months and these had been investigated thoroughly and people and their relatives were satisfied with their responses.

Good

# Is the service well-led?

## Our findings

The registered manager valued feedback from people and staff and acted on their suggestions. One person told us the registered manager had done a lot and the deputy manager had "brushed up" the staff. Three people and two relatives told us the home was well led. One person said both managers had told them, "If you are not happy tell us." Staff told us the registered manager and deputy manager were both very approachable and enabled staff to speak out about their concerns. One staff member said, "Support is brilliant, the deputy manager is always on the floor helping." Relatives had told staff they had seen positive changes since the new manager started.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Meetings were held with staff, heads of department, people and their relatives. A resident/relatives three monthly meeting was held in March 2016 when 23 people and their relatives attended. The minutes told us relatives had discussed meeting with the deputy manager about care plans and the extended handover period between staff shifts to allow an overlap period so people were not unattended during these sessions. One person commented they had difficulty remembering their supper choice from the previous and it was agreed they could choose the same day. Another person wanted their menu choice by their plate at each meal and we saw this had been achieved.

The latest customer satisfaction survey at the end of 2015 was also discussed at the March 2016 meeting. There had only been 10 responses to the survey and the results indicated satisfaction percentages for example, staff 60%, food and laundry both 90% and communal areas 50%. The registered manager discussed the refurbishment programme where all ensuites would be completely renewed and there will be new furnishings. Four empty rooms on the top floor were to be used while residents moved out of their rooms There were plans to refurbish and redesign communal areas. The registered manager had reminded everyone his door was always open and there was a time every month when he was always in his office to speak with people and their visitors. The date and time was on a notice board for all to see. The provider had indicated three areas to improve since the survey was completed. These were, staff available when needed, promptness of staff attending to needs of resident and staff know resident's needs. This was an ongoing action reviewed monthly.

The minutes from a nurses meeting held in April 2016 described the discussion of various clinical issues and how staff involved people and their families in the care planning and review process. Group supervision was completed at this meeting with regard to storing peoples care plans in their bedroom and achieving their consent. The service will be collaborating with King's College, London regarding a new dementia medicine.

We spoke with a clinical services manager who coached and supported staff weekly. A recent example was checking 'best interest' records for people and making sure staff understood the risks for people. They communicated their results to the registered manager to improve best practice.

Governance of the service included leadership by the area director and area manager who were also supported by the quality manager working with the service to monitor and support service improvement. A

programme of staff appraisal and individual supervision meetings was in place to ensure staff had the opportunity to discuss concerns and development needs with the registered manager.

Quality assurance systems were in place to monitor the quality of the service being delivered and the running of the home. We looked at a sample of audits for example, health and safety and infection control where there was 95% compliance. A medicine audit was completed monthly and the action plan had highlighted that liquid medicine was not dated when opened. We checked it had been completed. Nurse medicine competency audits had commenced six monthly and the registered manager had 8 to complete.

The service had a Service Improvement Plan for 2016 which was checked at monthly reviews by the area manager. The last review in May 2016 highlighted where improvements were required which included monitoring the call bell response times. Many items were in progress and some had been completed this year already to include a health and safety audit and a review of the meal service. A six monthly Internal compliance audit was completed by the quality manager and highlighted any additional improvements necessary which were checked monthly.

Monthly provider review visits to the home were completed by the area manager and shortfalls were looked at again the following month to ensure they had been completed. Reviews included conversations with people, relatives and where possible visiting external professionals to seek their views on the service. Information received was used to inform service development.

People were able to see a poster with 'What you said' and 'What we did'. For example people wanted wireless access to the internet and this was provided and people said their food was cold so the procedure was changed and all food was the correct temperature now.

There was a Residents Involvement Charter which they, relatives, advocates and staff had contributed to. The ten involvements had happened and included being part of recruitment, to be able to rely on the manager to progress action at resident/relatives meetings and being involved in a monthly review of planning and evaluating their care.

The Carehomes UK internet site rated Ashley House 9.6 out of 10 for quality using 22 comments from people in the last two years. Five people had commented in the last year and they said, "The staff are always very friendly and willing to help with all of her [mothers] needs including washing and dressing. I honestly don't know how they do their job and remain so positive", "All the staff have been extremely kind and helpful" and "I enjoyed my stay it was excellent. The staff were very helpful and kind."