Askham Village Community Limited

Askham Court

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Askham Court is registered to provide accommodation and care, with nursing, for up to 12 adults. It is part of the Askham Village Community, which comprises of four care homes, each catering for a different client group, built around a central courtyard garden. Askham Court is on one floor, with a large lounge/dining area, which has a kitchenette, and all bedrooms are single rooms with an en suite bathroom. There is a shared café opening onto the courtyard, which is open to the general public.

The inspection took place over two days and was unannounced. There were 11 people in residence. The last full inspection of Askham Court was on 27 September 2013. During this inspection we found that improvements were needed relating to the management of medicines. The provider sent us an action plan detailing the improvements they were going to make. In December 2013 we carried out a review of the evidence sent to us by the provider and found that the required improvements had been made.

Summary of findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager is also registered to manage Askham Place, one of the other three care homes on the site.

Staff had undergone training to recognise and report abuse. Any potential risks to people were managed so that people were protected from harm.

There were not enough staff on duty to keep people safe and meet their assessed needs. Pre-employment checks had been carried out to ensure that only staff suitable to work at the home were employed. Medicines were not always managed safely.

The CQC monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed by staff trained to do so. However, staff's knowledge was not sufficient to ensure that people's rights were protected if they did not have capacity to make decisions for themselves.

People were given a choice of food and special diets were catered for. People's health was monitored and maintained by staff with the involvement of a range of healthcare professionals.

Relationships between people who lived at Askham Court and the staff were very good and staff showed they cared about the people they were looking after. Staff treated people well but did not always uphold their privacy and dignity. People's personal information was not always kept confidential.

People and their relatives were not involved in the planning and reviewing of their care. Care plans did not contain sufficient, up to date information to give staff guidance on how to offer people consistent and personalised care and support. There were not enough activities, outings and entertainment offered to people to keep them occupied.

There was an open culture in the home and people, their relatives and other visitors were encouraged in a number of ways to put forward their views about the service and make suggestions for improvements. Audits carried out were not always effective in driving improvements in the quality of the service provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We have made a recommendation about upholding the rights of people who lack the mental capacity to make all their own decisions.

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

The service was not always safe.

There were not enough staff on duty to keep people safe. New staff were recruited properly so that only staff suitable to work at the home were employed.

People did not always receive their medicines safely.

Staff had undertaken training in safeguarding and knew how to keep people safe from abuse and harm.

Is the service effective?

Requires improvement

The service was not always effective.

Not all staff were aware of their responsibility to protect the rights of people who lacked the mental capacity to make all their own decisions.

People were supported by staff with the skills and knowledge to do their job properly.

People's nutritional needs were met and their health was monitored by the involvement of a range of healthcare professionals.

Is the service caring?

Requires improvement

The service was not always caring.

People's right to be treated with respect for their privacy and dignity was not always upheld.

People's personal information was not always kept confidential.

Staff were kind and caring and supported people to maintain their independence.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not always involved in planning their care and support. Care plans did not contain sufficient information for staff to deliver consistent, personalised care.

An insufficient amount of activities and outings were provided to make sure people were kept occupied.

People knew how to raise concerns or make a complaint about the service. Complaints were responded to and actions put in place to resolve any complaints made.

Summary of findings

Is the service well-led?

The service was not always well-led.

Audits carried out were not always effective in driving improvement in the quality of the service provided.

The home had an open culture and encouraged ideas for improvement in a number of ways.

The CQC was notified of incidents and events as required by law.

Requires improvement

Askham Court

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 was carried out by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications, which the provider had sent to us.

Notifications are information on important events that happen in the home that the provider is required by law to notify us about. The provider had completed a provider information return (PIR), which gave us some key information about the home, what the home does well and any improvements they plan to make.

We observed how the staff interacted with people who lived at Askham Court. We spoke with five people who lived there, 10 members of staff (one nurse, six care workers, two therapists and a member of the kitchen staff), two visiting healthcare professionals and the registered manager. We wrote to a number of health and social care professionals who had regular contact with the home and received comments from five of them. We looked at three people's care records as well as some other records relating to the management of the home, such as staff recruitment files, staff training records and some of the quality assurance audits that had been carried out.

Requires improvement

Is the service safe?

Our findings

People who lived at Askham Court, their relatives, the staff and external professionals all expressed concerns about the level of staffing. One person said, "They [the staff] take too long to answer the buzzer. They're always doing something else." Another person told us, "I feel there aren't enough staff to do things such as changing incontinence pads." People said they did not always get to their therapy sessions as they were not ready. This was because, for example, there were not enough staff to get them up in time or they were in need of assistance with personal care and there were not enough staff to help them. A healthcare professional expressed concern that people frequently had not arrived for planned therapy sessions because they were not ready. On the day of the inspection only two of the six people booked for the session had turned up.

Staff raised concerns about staffing numbers and the impact this had on people who lived at the home. They said that there had been times when therapies, activities and trips out had to be cancelled as there were not enough staff available. Sometimes staff from the other three care homes on the site would be sent to help out. A relative said that their family member felt worried because these staff did not always seem to know what s/he needed. This meant that people did not always receive consistent care because they were being supported by staff who did not know them well.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked how people's medicines were managed. Staff told us that they had undertaken training in administering medicines. They said that their competence to do so had been checked before they first started giving people their medicines. Records showed that people received their medicines as they were prescribed. Staff told us that one person had stopped looking after their own medicines. It was not clear from the person's care plan when they had stopped. There was a note in the evaluation of the care plan but the care plan itself had not been updated to show that staff were now administering this person's medicines. Prior to the inspection we had received information that a number of medication errors had taken place. For example, one person had been quite poorly after receiving too much of one medicine for several days. Unused medicines were not disposed of safely and staff we spoke with did not know the home's policy on disposal. There was no record of what happened to unused medicines when they left Askham Court. This meant that medicines were not always managed safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at Askham Court. One person told us "I feel physically safe here." Another person said, "I feel safe. No-one would hurt me deliberately. No-one has shouted at me."

Staff confirmed that they had received training in safeguarding and knew about the internal procedure to follow if they suspected abuse. We saw a poster on a notice board in the entrance foyer, which gave people information about abuse. This meant that people, their visitors and staff had access to information and relevant telephone numbers to report abuse if they needed to. Staff were aware of the provider's whistle-blowing policy and procedure. They told us they would feel confident in raising any concerns as they would be protected from recrimination. At the time of the inspection a number of issues had been reported to the local safeguarding team and investigations were being undertaken.

We found that there were systems in place to reduce the risk of people being harmed. Assessments of any potential risks to people had been carried out and recorded in people's care records. These included risks relating to not eating or drinking enough, falling, and developing pressure sores. These assessments had been reviewed regularly and updated when needed. One person, at risk because of their medical condition, had been assessed as requiring staff to check on them every 15 minutes. We saw that this took place.

Staff told us, and personnel records we looked at confirmed, that the provider had a robust recruitment procedure in place. All the required checks were carried out before the new staff member started work. This meant that only staff suitable to work at this home were employed.

Requires improvement

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to do their job properly. Staff confirmed that they had undergone an induction when they started work at the home. This included shadowing experienced members of staff and undertaking training in topics considered mandatory by the provider. A new member of staff told us they had received some information and guidance from the manager during their first two days and had undertaken training in some topics. They had then spent eight days shadowing experienced staff and had not yet worked alone. This showed us that staff were only allowed to work alone when they were deemed competent to do so.

Staff had undertaken further training in topics relevant to their work. They were expected to take refresher training at regular intervals to ensure they remained up to date with current good practice. Staff commented that the training was good. They said they felt well supported by senior staff and received supervision every four to six weeks.

Social and healthcare professionals reported to us that the therapy staff were excellent. They said that some people who had been admitted to the home for rehabilitation had done well and been able to return home. A relative told us that the physiotherapist was very good, and the hydro-therapist "excellent".

Records and our discussions with the staff member responsible for arranging training confirmed that nine of the 36 staff across two of the homes had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Assessments of people's capacity to make decisions about their care had been completed. These assessments had concluded that none of the people who lived at Askham Court needed to have a DoLS authorisation in place. However, staff we spoke with and records we looked at indicated that staff were not clear about people's mental capacity and what should be recorded to ensure staff had sufficient guidance in this area. A social care professional who had visited the home raised concerns that senior staff were unclear about the law in regard to MCA and DoLS. This meant that the rights of people who lacked the mental capacity to make all their own decisions might not have been upheld.

People were not very enthusiastic about the meals provided and they felt their choices for meals were limited. One person told us, "The food here is okay although not always as hot as it could be." Another person said, "The food here is acceptable, but boring. For example, we tend to have soup and sandwiches a lot in the evening." The third person told us, "They try to accommodate me food-wise but the food here isn't the best." One person said they would love a curry, but these were "in short supply". This meant that for some people the food options were limited.

Staff told us that people had a choice of main course for lunch every day. There were also alternative dishes available if people did not like either of the choices. A dietician told us that staff contacted them for advice in a timely manner and followed the advice they gave. They said that staff knew the residents' likes and dislikes well so they could tailor what was required around the foods they knew people liked. Kitchen staff told us that the lead nurse updated them so that they were fully aware of people's dietary needs and any changes required. People who required them were provided with special diets, including fortified foods for those deemed at risk of malnutrition. This meant that people were supported to maintain their health and well-being.

Care records showed that people were supported to access a range of healthcare professionals, such as the dietician, the dentist, the GP, and the psychologist, so that their health was monitored.

We recommend that the provider seeks advice and guidance from a reputable source, about ensuring that the rights of people who lack the mental capacity to make all their own decisions are upheld.

Requires improvement

Is the service caring?

Our findings

One person described the staff as "good" and "kind" and were pleased they could "have a laugh with them." They said the staff were polite and had never been rude. Social and health care professionals wrote and told us the good things about the home were the "pleasant staff", "good communication" and "excellent therapy staff". One said, "Staff are knowledgeable, friendly and approachable." Another described staff as "helpful and caring."

We saw that staff spoke with people in a caring, friendly way and that staff treated people with kindness and respect. There were good relationships between people who lived at the home and the staff, who we saw laughing and joking together. One member of staff told us that some people appreciated physical contact and liked staff to give them a hug.

Lunch was relaxed and unhurried. People were encouraged to eat and assisted if they needed it. Staff sat down with people to assist them. Staff explained to a person with impaired sight where things such as their drink had been placed on the table. They asked the person what they wanted to eat and told them what was on the plate when they put it on the table. They gave the person a plate with sides so that the person would find it easier to eat their meal.

One person told us they were able to make choices about the way they lived their lives. They said, "I can do whatever I want and often I get up for breakfast and go back to bed for a couple of hours."

Staff told us ways in which they supported people to maintain their dignity and privacy. They told us they always knocked on doors and waited to be invited in to people's bedrooms. They closed curtains and doors and kept people as covered up as possible when they were delivering personal care. One relative confirmed that staff always knocked on the door and waited for a response before entering the person's bedroom. However, they said that their family member's privacy and dignity had been compromised on occasions as staff had left the bedroom door open when delivering personal care.

We saw that people's personal records were left on the hand rail in the corridor outside each person's bedroom. These records were available for anyone to pick up and read. Personal information about people's food requirements related to their medical needs was on the cupboard doors in the kitchen, for anyone to see and read. This meant that people's personal information was not always kept in a confidential manner, which compromised people's privacy.

Requires improvement

Is the service responsive?

Our findings

People's care records contained care plans for each aspect of their care. There was no evidence in three of the plans we looked at to show that the person, or their relatives, had been involved in planning the person's care. One person told us, "I've never seen my care plan and I didn't know that I could see it." Two people's relatives said they had been involved in care reviews but had not seen or been shown their family member's care plan. One said they had explained numerous times to different staff about various aspects of the care their family member needed, but the care had not been delivered. For example, their family member liked a shower every day. Staff had told them they would have a daily shower but this had not happened in practice. This meant that the care being delivered was not always based on the person's preferences.

Care plans did not give staff the guidance and information they needed to make sure people received consistent, effective and personalised care. For example, one person who had severe behaviour issues was described as having 'unsociable behaviour', becoming 'agitated' and that they could be 'resistant to care'. There were no details on what this person would actually do and no guidance for staff on how to support the person in these situations. Vague statements, such as 'staff to be clear about the boundaries' did not assist staff to support the person consistently during these periods. This meant that there was a risk to the person, the staff and to other people.

We found in two instances that staff had not followed the guidance they had been given. For one person, their care plan, and written advice from the speech and language therapist, stated that the person needed pureed food 'the consistency of yoghurt, with no bits' to avoid choking. Staff told us they did not give the person pureed food but cut up their food into very small pieces. In another instance, staff had not followed the timings for calling 999 when the person had a medical emergency. On one occasion they had called 999 two minutes before the guide and another time had not called at all. These examples meant that people were at risk.

We found that none of the four care records we looked at were up to date. For one person, a relative was named as their next of kin, with their home address and telephone number for contact. However, this relative no longer lived at the address shown. These incorrect contact details were repeated in several different sections of the care plan, including on a document designed to be taken with the person if they were sent to hospital in an emergency.

Care plans had been evaluated monthly but any changes recorded in the evaluation had not resulted in the care plan being updated. This meant that care plans contained out of date and incorrect information. For example, for one person the length of time between checks of their continence aids had been reduced from four to five hourly in the care plan to three hourly in the evaluation. This was working towards the person's goal of regaining control of their continence. The out of date information meant the person might not have received consistent care from staff, which could have affected their progress.

Some information was missing altogether from the care plans. For example, one person was wearing a patch to try to stop smoking and another person needed special cutlery and a plate guard for their meals. This meant that people's care was not based upon the most up-to-date information about their care needs.

One person had care staff from a different provider to support them on some days. These staff made and kept their own notes and did not look at the home's care plans or daily logs. Askham Court staff did not see the notes written by the other provider's staff. This posed a risk that the care being delivered to this person was not consistent.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were pleased with the physiotherapy service they received. One person said, "The physio here is quite good and I feel that it's meeting my needs." Another said, I do like the physiotherapy service in this place", and the third person told us, "The physio is great." One person felt that they had "achieved a lot" since being at the home.

However, people, their relatives and staff told us that people did not always get the therapies they needed and had been promised. In one person's goals and activities folder we saw that in 20 days there were five records of the activity/goal not taking place "because short staffed". In another person's records, the log showed that the person had not been supported with their exercises every day, which they needed. One person felt they had not progressed "as fast as they could" because there were not enough staff to support them with the tasks they needed to

Requires improvement

Is the service responsive?

do in between therapy sessions. A relative told us their family member had been promised two sessions a week in the hydrotherapy pool, but had only been having one session a fortnight.

People told us that they were bored and "longed for" other things to do other than the therapy sessions. Staff told us that activities and outings "suffered" due to shortages of staff. Planned trips into the local community had been cancelled on a number of occasions. For example, a few days before our inspection one person had been due to go shopping with staff. This had not been possible so a member of staff had taken the person in the staff member's own time. One person had their own car but there had frequently been insufficient staff on duty to take the person out.

The provider had a complaints policy and procedure in place and people told us they knew how to complain. People said they would talk to staff or to their relatives. One person felt that their complaints had always been resolved. A relative said they had met with the manager on a number of occasions to try and iron out issues that had arisen. Staff were aware of their responsibility to support people to raise concerns if they wanted staff support. A social care professional told us, "I have a very good relationship with the manager of the home who is always open to being informed of poor service and concerns." They said that issues had been raised in the past, which the registered manager had responded to with a clear action plan. The action plan had then been implemented effectively.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager in post. They had been in post since October 2014. Records we held about the service confirmed that notifications had been sent by the registered manager to the Care Quality Commission (CQC) in a timely manner.

One relative said they had noticed improvements since the current registered manager had started working at the home. A member of staff said the home was "managed well" and they felt supported by the manager.

People, their relatives and visitors to the home were encouraged to give feedback on the service being delivered. A poster asking, "Does Askham make you smile?" was on a notice board in the entrance foyer, with instructions to the reader on how to put forward their views.

Staff told us they enjoyed working at Askham Court and worked well as a team. A new member of care staff told us the care and nursing staff had all been very supportive and that the atmosphere in Askham Court was very relaxed. One member of staff said, "I really love my job and working with people in the home." Another told us, "I love it here" and described how they found working with people very rewarding.

The home had some links with the local community. There was a café and function room in the shared area of the site, which were open to the local community as well as to people who lived in the four homes on the site, their relatives and visitors. The function room was available to local groups to hire and we found a village community newsletter in the lounge. However, people told us they did not get out into the local community as much as they would have liked to have done. This meant that for some people their social interaction and support for their interests was limited.

Audits of some aspects of the service provided were carried out regularly. For example there were monthly audits on infection control, care plans, medication and health and safety. Senior staff reported to the registered manager by completing a weekly return relating to a number of aspects of the service provided, such as staff sickness and supervisions, hospital admissions, pressure ulcers and maintenance concerns. We saw that, according to the records we were shown, a number of staff had received their last supervision in January or February 2014. The registered manager said this was a typing error and should have been 2015. However, this error had not been noticed before we pointed this out and therefore no action had been taken. This meant that although audits were carried out to ensure a high quality service was being provided, they were not always effective. In addition, audits completed by the registered manager had failed to identify the issues we found regarding people's care plans, guidance for staff and medicine management shortfalls.

The provider produced a newsletter in an easy-to-read style with pictures and symbols. We saw the March 2015 edition in the lounge. It included pictures from Halloween and Bonfire Night parties in 2014. The dates for relatives' meetings held quarterly were advertised and people were asked to share their views about the service. The newsletter included an organisation flow chart, listing key roles within the company and said 'hello' and 'goodbye' to staff joining and leaving. A future event, the Askham Cultural Day, which was being held in the function room in April was also advertised.

The provider told us they had carried out a written survey of relatives' views about the service. As a result of the feedback they received the registered manager told us she had just started to make a "courtesy call" to relatives each month to provide them with an update on their family member's progress and well-being. This gave relatives an opportunity to discuss any concerns or make comments on the service being provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not involved in planning their care and support. Care plans did not contain sufficient information for staff to deliver consistent, personalised care.** Regulation 9(1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not always managed properly and safely.** Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not enough suitably qualified, competent, skilled and experienced staff deployed to meet people's needs.** Regulation 18(1)