Embrace (England) Limited

Ashwood Park

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 inspection took place on 9 February 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

Ashwood Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashwood Park accommodates 65 people in one adapted building across five separate units. One of the units specialises in providing care to people living with dementia. On the day of our inspection there were 62 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in December 2015 and rated the service as 'Good'. At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care

specialists.

People who used the service and family members were complimentary about the standard of care at Ashwood Park.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred means ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service remained Good.	**Good**
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

Ashwood Park

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 9 February 2018 and was unannounced. Two adult social care inspectors, a specialist advisor in nursing and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people who used the service and four family members. We also spoke with the registered manager, a manager from one of the provider's other services, the clinical lead, an activities coordinator and six members of staff.

We looked at the care records of five people who used the service and observed how people were being cared for. We also looked at the personnel files for five members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Ashwood Park. A person told us, "Very well looked after and always feel safe with the staff." Another person told us, "I am here to keep me safe as I wasn't in my own home and it's ok, better than I thought." A family member told us, "My relative is cared for well and safe from any harm."

There were sufficient numbers of staff on duty to keep people safe. We discussed staffing levels with the registered manager and looked at staff rotas. Staffing levels varied depending on the needs of the people who used the service. Staff, people who used the service and family members did not raise any concerns regarding staffing levels at the home.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. The registered manager told us people who used the service joined in the interview process and were asked to speak to the candidates to be interviewed and give their opinion.

Accidents and incidents were appropriately recorded and analysed to identify any trends. Any actions or lessons learned were clearly recorded. Lessons learned were also fed back and discussed at staff supervision sessions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Risks to people's safety were identified and managed. This included an assessment of the level of risk and action taken to mitigate the risks to the health, safety and welfare of people. Risk assessments included moving and handling, mobility, falls, use of bed rails, nutrition and hydration, choking, continence, skin integrity, social isolation, urinary tract infections and self-medication administration. Records we saw were up to date.

The home was clean, spacious and safe for the people who used the service. The provider had a variety of infection prevention and control policies in place and audits were carried out regularly to ensure the home was clean and free from infection. Communal bathrooms and toilets were clean and appropriate hand washing facilities were available.

Equipment was in place to meet people's needs including hoists, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Hot water temperatures were carried out and within safe limits. Risks to people's safety in the event of a fire had been identified and managed, and people who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in

an emergency situation.

The provider had a safeguarding policy in place. We found the registered manager understood safeguarding procedures and had followed them, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people.

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed. Medicines audits took place monthly and a weekly check was also carried out. Staff received regular checks to make sure they were competent in their role of administering medicines. We saw a copy of the most recent pharmacy audit of the service and found there were no urgent actions required.

Some people required thickening agents to be added to foods and liquids to bring them to the right consistency or texture so they can be safely swallowed by people at risk of choking. Thickening agents were stored in unlocked cupboards and drawers in people's bedrooms. We spoke to the clinical lead who removed the thickening agents and stored them securely in the treatment room.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A person told us, "The staff must be trained to care otherwise they would not work here." Another person told us, "I was poorly a while ago and the doctor was here the same day, I only have to ask." A family member told us, "We are told when our relative is unwell and the home has links with excellent GP surgeries that respond quickly."

Staff were supported in their role and received regular supervisions and an annual appraisal. Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely. Additional training was also sourced from external specialists such as the mental health team and local hospice. New staff completed an induction to the service. The registered manager told us, "Staff come in for a couple of days and do 'meet and greet'. [Maintenance staff] does building and fire safety. They have two to three weeks to complete the e-learning." This was confirmed by staff. New staff were also enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

People were supported with their dietary needs. Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional health. For example, one person's care plan contained guidance to staff on preparing food in a way that reduced the person's choking risk. People's food and fluid intake was monitored to minimise the risk of malnutrition or dehydration. Food charts recorded the food a person was taking each day and included portion sizes, and fluid intake charts recorded the fluid a person was taking each day and fluid intake goals and totals were recorded.

One person was being fed via a percutaneous endoscopic gastrostomy (PEG) tube. A PEG is a procedure to place a feeding tube through the skin and into the stomach to give the nutrients and fluids needed, if people are not able to eat or drink. The person's support plan stated they were able to independently utilise their PEG tube and would ask for advice and assistance if they had a problem with it. Appropriate guidance was provided for staff. However, there was some conflicting information in the person's support plan which we discussed with the clinical lead and they updated the records at the time of the inspection.

We observed lunch, which was served in a quiet and calm atmosphere. The food looked appetising and people appeared to enjoy their meals. There was a choice of meals and these were verbally and visually offered. A person told us, "The food is fine, well cooked and a lot of variety. If I don't like the options they get me something different." Another person told us, "If I do not like the food on offer I ask for something different and it is no problem." A family member told us, "I have eaten at the home and the quality and presentation is good and the portions are not too large."

The Mental Capacity Act 2005 (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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to make decisions mental capacity assessments and best interest decisions had been completed for people. Records of best interest decisions showed involvement from staff and were decision specific however did not always record whether families had been involved. This was fed back to the registered manager who agreed to action.

Consent to care and treatment records were signed by people where they were able. If they were unable to sign a relative or representative, who was legally authorised, had signed for them.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place for some people. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service had been involved in the decision making process.

People's records contained a pre-admission assessment to assess people's needs before they moved into the home. This ensured that staff could meet people's needs and that the home had the necessary equipment to ensure the person's safety and comfort.

There was a system in place for people when they had to transfer between services. For example, if they had to go into hospital or be moved to another service. These documents detailed information about the person and their needs and preferences, and accompanied the person if they had to move to a different service.

Care records contained evidence of visits to and from external specialists including GPs, dietitians, falls team, occupational therapists, specialist nurses, head and neck specialist nurses and Macmillan nurses.

The service had a rehabilitation unit that integrated a number of services including occupational therapists, physiotherapists and social care professionals. These professionals shared best practice with the home's care staff, which the registered manager told us had led to a high ratio of people being successful in their rehabilitation and discharged back to their own homes.

Some of the people who used the service were living with a dementia type illness. The service had incorporated dementia friendly design into the environment. For example, communal toilets and bathrooms had red doors and were clearly signed. Hand rails contrasted with the walls and corridors were light and spacious. Dolls were placed around the home and some people had memory boxes outside their bedroom doors. Themed walls were on the first floor dementia unit and included a bus stop, florist, post office and photographs of famous music and movie stars. The registered manager told us people who used the service had chosen some of the displays on the walls.

Good

Is the service caring?

Our findings

People and family members we spoke with told us staff were caring. A person told us, "My carer took me outside for a cigarette. It was snowing and together we sat and looked at the snowflakes and tried to count them. They fell on our face and clothes and hair and it was the best feeling ever!" A family member told us, "My relative has a problem talking so sometimes feels uncomfortable but they are always included and has someone with them at the activities." Another family member had commented on a feedback website saying, "The care my [relative] received from Ashwood Park Care Home was outstanding. My [relative] was shown dignity, empathy, the best of care and most of all love by all the staff and it was quite clear to see that all the residents are loved so much."

A staff member told us that they had bought a small present for Christmas for each person who used the service. They had also bought presents for a family coming to have Christmas dinner at the service. The family had said this made them feel valued and included and they had thanked the staff for making Christmas Day "special".

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. We observed staff giving people hugs and dancing with people in the corridor. There were lots of laughter and smiles on the faces of staff and people who used the service. We observed a staff member kissing a person who used the service on the cheek. The person said, "Again" so the staff member kissed them again and they both laughed. We also observed compassion from a staff member who walked a person away from a pamper session as they were getting upset.

Staff respected people's privacy and dignity. We observed staff knocking on bedroom doors and asking permission before entering people's rooms. Notices were placed on bedroom doors stating, "Personal care being delivered". People told us staff always explain what they are going to do before they do it and ensure residents fully understand. Family members told us staff understood the need for privacy and avoiding any awkward moments. A family member told us, "When I visit if there are any 'difficult moments' the carers explain this to my relative and that I am coming back when things have been sorted out." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported to remain independent where possible and care records described what people could do for themselves. For example, one person's support plan described how they could follow prompts to wash their hands and face if they were provided with a flannel. A person who used the service told us, "They encourage me to do what I can very kindly and with such patience. I know I can be obstinate!" A staff member told us, "Whatever they [people who used the service] can do, we support them as long as possible. It doesn't matter how long it takes as long as they are doing it themselves. To them it's a big deal to still be able to do what they can do." This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Communication support plans were in place for people to help them engage in decision making and conversation. Two of the records we viewed were not specific about the person's individual communication needs. We discussed these with the registered manager who agreed to action.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us one of the people using the service at the time of our inspection had an independent advocate.

Good

Is the service responsive?

Our findings

Care records contained 'This is Me' documents and 'My Day' profiles, which included details about the person's life history and things that were important to them, such as particular events or family information. This allowed staff who had not supported the person before to familiarise themselves with that person's personal preferences. This information also supported the provision of activities which met people's needs.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. For example, one person's support plan detailed the routine they liked to follow, in that they liked their breakfast around 8.30am, enjoyed watching TV in their room and enjoyed visits from their family. For another person their support plan detailed that they enjoyed going out during the day with friends and spend time completing jigsaws.

Support plans included physical well-being, diet, mobility and personal hygiene. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. Support plans were reviewed and updated at least once a month to ensure they contained relevant information.

People living in the home were at varying risk of pressure ulceration. Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. People had detailed support plans to inform staff of the intervention they required to ensure healthy skin. We saw the system that was in place if people were being cared for in bed and needed re-positioning at regular intervals to maintain their skin integrity. However, for one person we saw conflicting information in their care file directing positional changes to be undertaken "regularly", "two hourly" and "four hourly". We discussed these inconsistencies with the clinical lead and they told us they would review the person's care records.

The registered manager told us they encouraged an "open approach to end of life care". The service was supported by Macmillan nurses, who they could share experiences and discuss outcomes with. Senior staff had received end of life training and there was a plan in place to roll this out to all staff. End of life care plans were in place, which described people's preferences for their end of life care. We saw a letter from a family member praising the service for the end of life care provided to their relative. The letter stated, "[Staff] showed genuine affection towards [name]. She and we couldn't have wished for her being better looked after in her final months. The care and attention to make her as comfortable as possible was professional but also dignified, caring and humane."

Daily communication notes were kept for each person. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported.

We found the provider protected people from social isolation. Activities at the home included exercise sessions, singalongs, pamper sessions, external singers and entertainers, and trips out in the provider's

minibus. We spoke with the activities coordinator, who told us about the activities offered at the home. These were person specific and one to one activities were provided for people who were unable to attend group sessions. A person told us, "It is nice to do things whilst I still am able. I like the singing and music times." Another person told us, "I do like to join in and some of the activities are fun." Another person told us, "I choose not to join in a lot of the activities and that's fine. They always ask me though which is thoughtful."

The provider had a complaints policy and procedure in place. There had been two recorded complaints in the previous 12 months. We saw these had been appropriately recorded and actioned. People and family members we spoke with were aware of how to make a complaint but did not have any complaints about the service.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since November 2016. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us about the refurbishment plans for the home. They also told us about the dignity champions at the home and their plans to complete additional training that would be cascaded to staff, and plans for achieving the 'Gold standards framework' for palliative care.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community. These included the local church, Salvation Army, schools and nursery school who were all regular visitors to the home. The service had links with a local college and offered placements to health and social care students. The service also sponsored a local junior football team.

The service had a positive culture that was person centred and inclusive. The registered manager told us they had an open door policy and staff, people who used the service and family members we spoke with confirmed this.

Staff felt supported by the management team and were regularly consulted and kept up to date with information about the home and the provider. A staff member told us, "The unit runs really well, staff all work together. We're good team workers and there is good support." Another staff member told us, "I love my job here. I'm quite happy doing what I'm doing. It's a real partnership between everyone." Another staff member told us, "If we have any concerns we mention them to the seniors, it gets taken to the manger and is always resolved" and "If we ask, it gets followed through".

Staff meetings took place regularly and included updates on the service, staffing and rotas, holidays, training and any other business. Flash meetings also took place regularly where the registered manager met with senior staff from each department to discuss any issues and receive updates. The registered manager told us a member of staff was a member of the 'Staff council', who attended regular meetings with other representatives from the region to discuss and develop best practice in care homes.

A person who used the service told us, "This is a great place and well run and the management know how to deliver a brilliant service." Another person told us, "The manager can always take time to calm worries and make everyone they talk to feel special." Another person told us, "I cannot think of anything I would improve, it really is a lovely caring home."

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

We saw a copy of the provider's audit timetable, which included medicines, care planning, pressure care and infection control. All the audits carried out by the registered manager were entered on the provider's electronic system so they could be reviewed by senior management.

The provider carried out a monthly visit to the home, which included discussions with people, visitors and staff, a review of care and medicines records, a review of staff files, an inspection of the premises, and a review of accidents and incidents, events and complaints. An action plan was created if any issues were identified at each visit. We saw where actions had been identified, they had been addressed.

Residents' meetings took place regularly where people could discuss activities, the quality of care, food and cleanliness of the premises. Relatives' meetings were also held but were not well attended. The registered manager believed this was due to their "open door policy" and if family members wanted anything or had any questions, they were dealt with at the time rather than wait for meetings. Annual surveys were carried out of people who used the service and family members. We saw the results from the 2017 surveys were positive and where issues had been identified, action had been taken. This was in the form of a "You said, we did" response.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.