Ms Cherie Reynolds

Ashgrove Care Home

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

The inspection took place on 17 December 2015 and was unannounced.

Ashgrove Care Home is registered to provide accommodation with personal care for up to a maximum of 10 older people.

There was a registered manager in post who was present during our inspection. 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.

This was the first inspection for this service since a change of ownership and registered manager in May 2015. During the registration process we identified that the completeness and quality of records was very poor. It was recommended that the provider completed an action plan and make improvements. We found that

Summary of findings

improvements had not been made. We found that care plans and care records were brief in detail and did not always reflect the level of people's needs and the support that was needed to meet those needs.

There was weak leadership in the home that failed to give staff direction and recognise the needs of the people using the service. There was a lack of effective monitoring systems to identify any areas for improvement and as a result people's health and wellbeing was compromised.

Risks to people's health and well-being had not been consistently assessed. It was not clear what actions had been taken following accidents and incidents to reduce the risk of further harm.

People's nutritional needs had not been assessed and monitored in line with the provider's policies. Contact with health professionals had not always been recorded and it was difficult to establish if or when contact had been made in relation to people's health needs.

The home was not always kept warm and comfortable for people.

The views of people and relatives were not actively sought and people were not involved in decisions about the service.

People told us they felt safe living at the home as there was always staff around to help them. All staff had been given training in keeping people safe. Staff were aware of how to identify signs of abuse and who to report concerns to.

People told us there were enough staff to meet their needs. The provider had completed checks to ensure staff were suitable to work at the home.

People received their medicines safely and when they needed them. Medicines were stored securely and accurate records maintained. People could see health care professionals as and when needed.

Staff sought people's consent before they supported them and encouraged people to make decisions for themselves. Staff knew people well and were aware of their needs, preferences, likes and dislikes. People were able to choose how they spent their time and staff respected their choice.

People told us they enjoyed the food and had a choice of what to eat and drink.

People and relatives felt confident and able to raise concerns or issues with staff or the registered manager. However the complaint procedure was not up to date.

People and relatives told us that staff were kind and caring. People were treated with respect and their dignity and independence was promoted.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe

People felt safe living at the home but risks to their health and wellbeing had not been consistently assessed. There was no system in place for reviewing accidents and it was unclear what if any action had been taken to reduce the risk of further harm to people.

Requires improvement

Is the service effective?
The service was not consistently effective

People's nutritional needs had not been assessed and monitored. It was not always clear if or when people had been referred to health care professionals. People were supported by staff in making decisions about their day to day care and treatment but improvements were needed to make sure their human rights were protected.

Requires improvement

Is the service caring?
The service was not consistently caring

People were not always kept warm and comfortable. People told us that staff were kind and caring and that staff respected their privacy and dignity People felt staff listened to them and gave them choices that helped them to maintain their independence.

Requires improvement

Is the service responsive?
The service was not consistently responsive

People were not involved in the planning of their own care but they could choose what they wanted to do and where they wanted to spend their time. People felt confident and able to raise concerns or complaints about the service but the provider's policy was outdated

Requires improvement

Is the service well-led?
The service was not well led

There was weak leadership in the home that failed to give staff direction and recognise the needs of the people using the service. The provider did not complete any checks to monitor the quality and safety of the service. The provider did not have systems in place to ensure staff were competent in their role. There provider did not seek people or relatives views on the service in regards to any decisions about the development of the service.

Requires improvement

Ashgrove 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 17 December 2015 and was unannounced.

The inspection was carried out by two inspectors.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service provided. We were also contacted by members of the public who shared their concerns about the service with us. We used this information to plan the inspection.

We spoke with six people who lived at the home. We spoke with four staff including the registered manager and care staff. We spoke with two relatives and one visiting health care professional. We viewed the care records of seven people in regard to assessment of needs, risks, their medicine and daily records. We also viewed records relating to the management of the home which included accident and incident forms. We also observed people's care and support and how staff interacted with people.

Requires improvement

Is the service safe?

Our findings

The registered manager told us due to the small size of the service they were aware of any accidents or incidents that occurred and any action taken as a result. However, they did not have a system in place to oversee the forms or to analyse possible trends in order to protect people. We found that one person had fallen seven times since May 2015. The registered manager told us the person's abilities had deteriorated and they had met with other professionals and the person was moved to another home. However, when we checked this person's records their was no evidence of discussions with other professionals or what the outcome was. Staff were aware of their responsibility to report accident and incidents, however we found that accident and incident forms were not always completed. The completed forms were brief in detail and did not always provide details of the incident or action taken to minimise further falls or harm. For example one form recorded 'reaching for a sweet' and contained no detail about the fall or action taken as a result.

People told us they would tell staff or their family if they had any worries or concerns about their safety and wellbeing. Staff we spoke with had not received training in protecting people from abuse but were aware of the different types of abuse. They would report any concerns to the registered manager or other workers. The registered manager understood their responsibilities for reporting their concerns to the appropriate agencies. The registered manager had not recruited any staff since being in post but understood their responsibilities to complete checks on staff to ensure they were suitable to work at the home.

People we spoke with felt safe living at the home as there was always staff around to help them. Staff told us they kept people safe by ensuring that their call bells were in reach, that they used their walking aids and by making sure walkways were kept clear. While staff were able to explain how they kept people safe we found that the only risk assessments completed were in relation to burns and scalds. There were no written risk assessments in place for key areas such as falls management and nutrition. Therefore we were unable to see what actions had been put in place to reduce the risks to people's health and wellbeing.

People told us there were enough staff and that they did not have to wait long for staff to attend to them. One person told us that they were not able to walk on their own in case they fell. They said they would call staff and they would walk with them. Another person told us they had just come home from hospital and needed a little more help from staff until they had recovered. We saw that when they asked staff for help they responded in a timely manner. The registered manager told us they worked alongside care staff and were aware of changes in people's needs and would arrange extra staffing if people's needs increased.

People told us they were given their medicine when they needed it. We saw that people received their medicines safely and accurate records of medicines were maintained. Medicines were stored and disposed of in the appropriate manner. Staff told us that only staff who had received medicine training administered medicine. We saw that people were supported to take their medicine in a patient manner and were given a drink to help them take it.

Requires improvement

Is the service effective?

Our findings

We saw that that one person had lost a significant amount of weight in a short period of time and it was not clear what had been done about this as a result. A staff member told us that they weighed people on a monthly basis. They said they had realised the person had lost weight and had discussed the situation with healthcare professionals who were monitoring the situation. In the meantime they said they were encouraging the person to take milky drinks as they disliked supplements. However, when we checked the person's care records there was no record of any discussions with health care professionals that had taken place or what the outcome was. The provider's policy stated that people's nutritional needs would be assessed and they would complete a Malnutrition Universal Screening Tool. Staff had not done this, we saw that people's weight was recorded in their daily records which made it difficult to monitor any changes to people's weight. Although staff told us they would use food and fluid charts should they have concerns about people's nutritional intake they had not put these in place for this person.

This was a breach of Regulation 14 Health and Social Care Act 2008(Regulated Activities) Regulations 2014

The registered manager told us that people had a choice of what they would like to eat and drink. They would arrange for people to have an alternative meal if they did not like what was on the menu. People we spoke with had mixed views about the choices of food available to them. Some people told us they were offered a choice of what they wanted to eat and could ask for an alternative if they did not like what was on offer. One person said, "The food is good". However, another person said although they we are offered a choice this sometimes changed and they did not know what they were having until it arrived. Staff told us they aware of people's nutritional needs such as who required a diabetic diet and what people's likes and dislikes were. This was confirmed by people we spoke with. We were told and saw that a record of foods people disliked was kept and that this was reviewed as people's tastes changed.

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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

We found that both the registered manager and care staff had not received training in the MCA or DoLS and had limited understanding of the Act. Staff were unaware of the implications for their practice should people's needs change and they became unable to make decisions for themselves. We saw that a blanket approach had been adopted as MCA assessments had been completed for every person living at the home. None of the assessments recorded what decisions they were assessing the person's ability to make and therefore showed that staff and the registered manager did not have a full understand the principles of the MCA. When we spoke with the registered manager they told us they were not aware of the gaps in their staff's knowledge. They said they would make arrangements for them and staff to undertake MCA training as soon as possible to ensure people's rights were protected.

People told us staff asked their consent before supporting them. One person said, "They [Staff] come in and ask me if I am ready". Staff said they always checked with people before supporting them. If people declined support they would withdraw and return later or ask another staff member to attend.

Staff told us they did not have formal supervisions or appraisals but could approach the registered manager or other staff if they wanted support or guidance. Staff told us they were all currently undertaking an accredited care course arranged by the registered manager. When we spoke with the registered manager they told us they regularly spoke with staff on an individual and group basis. They acknowledged that a more formal approach to supervision would enable them to identify and monitor staff development needs. They agreed to review their current supervision process.

Requires improvement

Is the service effective?

People told us that if they wanted to see the doctor or the nurse, they would ask the staff and they would arrange it. We heard one person ask staff about their leg and staff telling them that they would ask the health care professional to take a look when they visited later that day which we observed happening. We spoke with a visiting health care professional who told us that they had regular contact with the service. They told us staff requested them to visit if they had any concerns and would follow any advice they gave them.

Requires improvement

Is the service caring?

Our findings

We found that people were not always kept warm and comfortable as some areas of the home were cold. The small lounge was cold and was not occupied by people during our visit, the hallway was also cold. A person sat in the main lounge told us their hands were cold. They told us that some staff turned the heating on automatically whereas they had to ask other staff to do this. Another person we spoke with told us they were warm but that sometimes the home could be draughty. We found that people's bedrooms were warm apart from one where the person told us they chose to have the window open. This person was able to turn their heater on and off and chose to turn it off at night. When we spoke with the registered manager they had not recognised that the home was cold in some areas. We asked them how they would address this issue and they assured us that the home would be kept warm for people. They told us that they would place additional heaters in each lounge as well as thermometers which they would check regularly to ensure that the rooms were kept warm and comfortable.

People told us that staff involved them in decisions about their care and asked them about the support they wanted. They said staff spent time with them and listened to what they had to say. One person told us they did not need a lot of help and that staff only helped them with what they could not do. They said, "They [Staff] get used to you and what you want". Another person said, "They [Staff] are so good all of them". A staff member entered the room and this person commented that the staff were always cheerful. During our visit we saw that staff spoke to people in a kind and considerate manner. We heard lots of friendly chats and it was clear that staff had formed effective relationships with people and knew them well People and relatives told us that staff were friendly and kind. One person said, "They [Staff] are nice, they [Staff] are all very kind". People told us that staff helped them keep in touch with people who were important to them.

People told us that staff treated them with dignity and respect. People told us they could meet with friends and family in the privacy of their own room. We saw that staff spoke with and about people in a respectful manner. Staff told us they promoted people's dignity by ensuring doors and curtains were kept shut when giving personal and by helping them to do as much as they could for themselves. One person said that they wanted to remain as independent as possible and staff respected this only providing support where needed. Staff recognised the importance of keeping people independent. One staff member explained that they would not do things for people when they were able to do it themselves as they may be upset by this.

Requires improvement

Is the service responsive?

Our findings

The provider did not make sure that people's needs were kept under review in a timely way. For example, one person had recently been admitted to hospital following a fall, their care needs had changed but the provider had failed to recognise this and take appropriate action to support the person upon their return to the home. The provider had not taken into account equipment that the person needed and this resulted in the person being readmitted to hospital. The registered manager had since spoken with the hospital and agreed to take the person back at the home. However, they had not visited the person to determine if their condition had improved and what level of support and equipment was required to meet their needs. This indicated they had not learned from recent experience of the person having to be re admitted because they were unable to meet their needs.

People told us that staff knew them well and knew how they wanted to be supported. Staff told us that people were able to make their views known and they would offer them choice. Staff told us that they were made aware of changes in people's needs during handover and would discuss any changes during their shifts but no written record was maintained.

People told us they could chose to spend their time as they wished. Some people chose to sit in the lounge whereas others chose to sit in their bedrooms and enjoyed reading. People said staff would take time to sit and chat with them which they enjoyed. One person told us that there was not much to do but, they enjoyed visits from children of the local school who visited once a week. They enjoyed their company and having a chat with them. Another person said that they sometimes played bingo. Staff told us that a person used to come in and do exercises with the people but this had now stopped. They said they occasionally they played bingo. They had time to sit and chat with people and had been singing carols with people in the run up to Christmas. The registered manager told us that people had opportunities to partake different activities such as exercise, bingo and liked to read and do puzzles.

People we spoke with told us they did not have any complaints but that they would be happy to raise concerns or complaints with staff or the registered manager. The complaints policy was not displayed within the home and did not contain up to date details of who to contact if they were not satisfied with the provider's complaints process. The registered manager agreed to update the policy and make it readily available for people to access.

Requires improvement

Is the service well-led?

Our findings

The registered manager was also the provider and took ownership of the home in May 2015. They told us they had found the takeover difficult as many changes and improvement needed to be made. During the registration process we identified that the completeness and quality of records such as care plans, daily notes and risk assessments were very poor. This had made it difficult to monitor people's needs and identify any changes. We recommended that the provider completed an action plan in order to improve the shortfall in record keeping. Prior to the inspection we had received concerns that the home was cold. The registered manager had told us they would take measures to address the concerns. At our inspection we found that an action plan had not been put in place and improvements had not been made. Care records remained disorganised and poorly maintained and we found that the home was cold in some areas.

There were no systems in place to drive improvement in the service. The registered manager told us that managing the home was all very new to them and they had not completed any checks on the quality and safety of the service. We saw that people's care plans were brief in detail and it did not always reflect people's needs or advice given by healthcare professionals. It was not clear when these documents had been completed or reviewed as there were no dates recorded. It was therefore difficult to monitor changes in people's needs and what action if any had been taken. For example we saw that a health care professional had recommended that staff increased a person's calorie intake. While staff told us that they had increased the person's meal portions this was not reflected in the person's care plan or care records. We also found risks assessments had not been completed in key areas such as falls and nutrition in line with the provider's policies and procedures and the needs of people living at the home. This had not impacted on people's care but meant that records were not kept accurate and up to date.

We found that some records relating to the management of the service were out of date or inaccurate. For example the provider's complaint procedure was significantly out of date and did not have the relevant contact details should people not be satisfied with the outcome of their complaint. There were no accurate records of staffing at the home. The staffing rota we were shown did not reflect the staffing levels on the day of our inspection or what the staff or registered manager told us. When we spoke with the manager they told us they had no formal system for determining staffing levels but would adapt levels in line with changes in people's needs. The lack of effective monitor systems meant that shortfalls in service we found had not been identified or acted upon.

Whilst people, relatives and staff found the registered manager friendly and approachable we found that they did not involve them in decisions about the development of the service. For example the registered manager had recently completed some refurbishment to the one lounge and removed the television without consultation with people that lived in the home. The registered manager told us that they did not complete any satisfaction surveys or hold meeting for people and relatives to give them opportunities to discuss their views. They had regular discussions with staff but did not record minutes of these meetings.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

By law the registered manager must notify CQC of certain events, these are called statutory notifications. Two people had recently been admitted to hospital with injuries CQC had not received any statutory notifications of these injuries. The registered manager told us they were not aware that CQC should have been notified. This meant that the registered manager was not acting in accordance with the legal requirements.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider had not ensured people's nutritional needs had been assessed and that they received adequate nutrition**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was a lack of systems in place to ensure the service operated effectively**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider had not notified the Commission without delay of serious injuries to a people who used the service**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.