Health & Care Services (UK) Limited

Ashfield Lodge

Inspection report

Ashfield Road
Sleaford
Lincolnshire
NG34 7DZ

Tel: 01529307330
Website: www.craegmoor.co.uk

Date of inspection visit:
14 December 2015

Date of publication:
04 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 December 2015 and was unannounced.

The home is in a purpose built building all on one level. The home is registered to provide accommodation with nursing care for a maximum of 20 older people or people living with a dementia. There were 20 people living at the home when we inspected all of whom required nursing care. There was also a day care centre attached to the home but this was staffed separately.

At the time of our inspection there was a manager in post who had applied to become 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.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. People's abilities to make decisions were assessed and where necessary DoLS authorisations were in place. However, conditions applied to DoLS were not always included in people's care plans.

Staff were kind and caring and spoke with people in a way which respected their privacy and dignity. There were good relationships between people and their care staff and these were supported to grow with people able to have their preferred care worker give care.

People received care from a staff team which was supported to develop and maintain the skills needed to provide safe care through on going training. The provider had a set staffing level, but at times they were unable to ensure that the home was staffed to these levels due to staffing shortages. Staff on shift worked to ensure people's needs were fully met.

The provider completed appropriate checks to ensure staff were safe to work with people living at the home. Other risks to people while receiving care were also identified and care was planned to ensure that people were safe. However, where people had experienced harm it was not always clear what action had been taken to keep them safe in the future.

People were supported to maintain a healthy weight and to stay hydrated. They were offered a choice of food and appropriate adaptive equipment was available when needed.

People's care plans accurately recorded the care they needed and staff also knew people's needs. Care was provided in a person centred way to meet those needs and people were supported to maintain hobbies and

activities they enjoyed. People were supported to access healthcare when a need was identified.

Staff told us that the deputy manager was supportive and available to them. However, the manager was not supportive and did not always take appropriate action when issues were raised with them. In addition, we saw the manager had failed to tell us about a number of incidents they were by law required to disclose to us.

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 consistently safe.

Staff knew how to keep people safe from harm and how to raise concerns internally and with external organisation. In addition care plans identified risks to people and how to keep people safe.

Staffing levels did not always match the level the provider had identified as needed. However, staff ensured people's needs were met.

People received their medicines safely. However more information was needed to support staff to consistently administer medicines prescribed to be taken as required.

Is the service effective?

Requires Improvement

The service was effective.

Staff were supported to maintain and develop skills needed to care for people safely. Staff felt supported by the deputy manager.

The provider ensured people's rights were protected under the mental capacity act. However, conditions identified when DoLS were authorised were not always included in the care plans.

People were supported to maintain a healthy weight and to stay hydrated.

Is the service caring?

Good

The service was caring.

People were supported to make choices about their care.

People had good relationships with staff who provided care which supported their privacy and respected their dignity.

Is the service responsive?

Good

The service was responsive.

People's care needs were fully documented and regularly reviewed. Staff provided care in line with people's identified needs.

People were supported to maintain hobbies and interests and to lead a meaningful life.

The provider managed and responded to complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Staff did not feel supported by the manager and the manager did not always respond when concerns were raised. The provider had not always told us about incidents they are required to tell us about by law.

There were systems in place to monitor the quality of service provided and people were supported to identify improvements to care.

Ashfield Lodge

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 14 December 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed 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 also reviewed other information we held about the provider including information on events they are required to tell us about by law.

During the inspection we spoke with one visitor to the home. Some people had problems with their memory and were unable to tell us about their experiences of living at the home. Therefore, 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. We also spoke with three care workers, the cook, the deputy manager and the area manager.

We looked at four people's care records. We also looked at records relating to the management of the home which included staff training, complaints and the quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Monthly dependency assessments were completed to identify if there were any changes in the level of support people needed. However, these were not used to inform staffing levels. The area manager told us how staffing levels were set at the same level across similar homes within the company. Nevertheless, the manager was able to raise concerns with the area manager if they felt staffing levels impacted on the quality of care people received.

The manager had not ensured there were enough care workers employed to be able to deploy staff to meet people's identified needs. In addition, care workers were working extra shifts to ensure people were not left without support. For example, the deputy manager was having to take time away from managing to provide care as there were no other nurses to cover shifts. However, they told us that sometimes they had to interrupt care as they were needed for management tasks such as interviewing for more staff.

Records showed that at times shifts had not always been staffed in accordance with identified staffing levels. In addition, care workers told us that sometimes they were prevented from caring for people as they had to support the day care unit by fetching people to the service and return them home. Care workers told us they tried to ensured reduced staffing levels did not impact on people having their needs met and records showed appropriate checks and care had been completed. One member of staff told us, "Care workers work very hard and go above and beyond to meet people's needs." We saw that one person needed individual support and staff told us and records showed this was provided.

The provider had systems in place to ensure they checked if staff had the appropriate skills and qualifications to care for people before offering them employment. For example, we saw people had completed application forms and the manager had completed structured interviews.

The required checks had been completed to ensure that staff were safe to work with people who lived at the service. The manager had employed one person who had disclosed at interview issues identified while working for a different service. The manager had investigated the concerns and reviewed the risks of employing the person. However, systems had not been put into place to show what additional monitoring was needed to ensure similar issues did not reoccur..

We identified that there was an unpleasant odour in some parts of the home. For example, in one of the lounges. Staff told us and records showed that systems were in place to keep the environment clean and to reduce the risk of cross infection. We discussed the odour issue with the deputy manager who had identified the carpet needed replacing and plans were in place for this.

Staff used appropriate equipment and systems were in place in the laundry and kitchen to keep people safe from the risk of infection. For example, in the kitchen food was stored appropriately and the temperature of cooked food was checked before it was offered to people. Staff had received appropriate training in relation to infection control and could tell us about the steps they took to reduce the risk of infection. In addition, audits were in place to ensure infection control processes were followed.

Staff had received training in keeping people safe from harm and were clear on the steps to take to report harm both within their organisation and externally. Contact details for the local authority safeguarding team were available in the staff room.

The provider is required by law to tell us about any specific concerns they have about people's safety. However, we identified a number of minor concerns they had not notified us about. In addition there was a lack of detailed follow-ups to these incidents. Therefore, we could not be assured that the risk of a similar incident occurring had been reduced.

Where people displayed behaviour which was not normal for them the nurses monitored their health to identify if there was an underlying cause such as a urinary tract infection or pain. Appropriate care plans were in place to support staff to care for people who displayed behaviour which may challenge. In addition, people were referred to the community mental health team for support and guidance when their behaviour put themselves and others at risk. One relative told us staff dealt with challenging behaviour well. They said, "When [my relative] shouts staff talk to him and they calm them down."

Risks had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Appropriate equipment was in place to reduce the risk of occurrence. Care workers explained how they ensured that people used the appropriate equipment that had been prescribed for them.

Systems were in place to support the safe administration of medicines. For example, the medicine administration records were colour coded to the medicine administration system. This made it clear to staff which time of day each medicine needed administering. The deputy manager was aware of people's specific medicine needs so that care could be tailored. For example, two people needed to take there medicines before they got up and one person needed their medicine at 6am to prevent symptoms of their condition impacting on their abilities during the day.

We saw one person was routinely refusing to take their medicines. We discussed this with the deputy manager who explained that they would take some but not all of their medicines. The issue had been raised with the GP who identified which medicine it was more important for the person to take and the important medicines were offered to the person first. This information was clearly recorded in the person's care plan.

Care plans did not contained information to support staff to administer medicines prescribed to be taken as required. For example, medicines to calm people down when they got distressed. In addition, there was no recording of why people had been given medicine prescribed as required to show that staff had tried to support the person through other mechanisms before resorting to medicine.

Requires Improvement

Is the service effective?

Our findings

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.

We saw where people may not be able to make a decision they had their abilities assessed. If they were unable to make a decision this was made in their best interest involving family and healthcare professionals. In addition, one person had an advocate; this was an independent person who could act on the person's behalf when decisions were made. Furthermore the staff were aware of when people had legally nominated a person to make decisions on their behalf.

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 13 people at the home had been assessed and found to need their liberty deprived to keep them safe. In each case the provider had a copy of the DoLS and the conditions on people. However, we saw information relating to the conditions placed on DoLS were not always transferred to people's care plans. For example, One person had a condition that they could be detained at the home provided they went for a walk every day. The deputy manager told us that this was not happening at present as the person would refuse to return to the home. However, they had not referred this back to the authorising agency for review.

People received care from staff that were supported to develop and maintain the skills needed to provide safe care for people. Staff had received training in how to care for people living with a dementia which included how to live a meaningful life and maintain their dignity. Staff employed by the service had a detailed induction that included working with an experienced member of staff. In addition they were observed giving care and were not allowed to work independently until they had shown they were competent to provide safe care.

Records showed that the staff had received training in line with the provider's policy and staff told us their training was up-to-date. In addition, staff were supported to complete qualifications for their current role and future development. For example, the head housekeeper was completing nationally recognised qualification in housekeeping.

Records showed that some staff had not received regular formal supervision in line with the provider's policy. Supervisions are important as they allow staff and the manager to discuss their work and to raise concerns and identify training needs training needs. However, staff said they felt supported at all times in

their role and they could approach the deputy manager with any concerns or issues. The deputy manager told us that if they identified any member of staff giving poor care a supervision would be completed.

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Their food was modified to increase their calorie intake, for example, potatoes were mashed with cream and butter instead of milk. Where necessary people had been supported with prescribed high calorie supplements.

People were given the right adaptive equipment they needed at mealtimes in order to eat independently. For example, one person was given a plate guard to enable him to eat his lunch. Where people needed to support to eat and drink care workers were encouraging and took their time to ensure the person had enough.

Meals were on a four week rolling menu which were set by the district catering manager with input from the home's chef to support people's likes and dislikes. People were offered a choice and the chef visited everyone each morning to see what they wanted for lunch. However, if someone changed their minds during the morning then an alternative would be arranged.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Where people displayed behaviour which was not normal for them the nurses monitored their health to identify if there was an underlying cause such as a urinary tract infection or pain. Appropriate care plans were in place to support staff to care for people who displayed behaviour which may challenge. In addition, people were referred to the community mental health team for support and guidance when their behaviour put themselves and others at risk. One relative told us staff dealt with challenging behaviour well. They said, "When [my relative] shouts staff talk to him and they calm them down."

Good

Is the service caring?

Our findings

A relative told us that care workers were kind and caring and that they spoke with people in a way which supported their dignity. For example, when care workers offered people the toilet they got close to the person and spoke quietly so that other people did not overhear. In addition we saw a person being helped to have their rollers removed and her hair combed. The person was happy that they looked smart.

Care workers understood the behaviours of people living at the home and reacted in a prompt manner if someone needed extra support. This was done in a caring way that did not rush the person. For example, we saw one person that was upset and tearful. The care worker knew how to reassure the person and integrate them with the group. The care worker encouraged the person to dance with them as they had liked to dance when they were younger.

However, we saw that people's independence was not always respected. We saw that one person had eaten their main course independently, but when a care worker brought their dessert they supported the person to eat. We raised this with the care worker who told us that when they person was tired they needed more support. The person's care plan recorded that they were independent with eating and no extra support needs around eating were identified.

Care plans contained information to help care workers communicate effectively with people living at the home. People's emotional needs were recorded in their care plan along with guidance for care workers on the support to provide. For example, one person's care plan recorded that when the person shouts it was because they were frustrated and that care workers should go to them and give them time to voice their concerns.

Relatives told us that people's choices were respected. For example, one person did not shower as this would require support from care workers and invade their personal space. The person was able to have a good wash every day independently.

Where people were unable to make decisions staff consulted with family members to ensure they knew the person's preferences. For example, one person was refusing to take their medicines. Following discussions with the family the medicine was now being given to the person with some chocolate and they were happy to take it this way.

Personal care was undertaken in the person's own room or the bathroom and care workers always asked people about carrying out care before they started. For example, one person was identified as maybe needing to return to bed. The care workers asked them and once they had agreed to return to their bedroom, the care workers hoisted them in a dignified and caring manner.

People who lived at the home could choose where they spent their time. There were two lounges and we saw some people preferred to be in the quieter lounge, while others chose to move between the communal areas and their bedrooms. There was a secure garden that people could access which looked inviting and

was well maintained. People were supported to identify that their bedrooms were their own private space by having their doors decorated to look like a front door. In addition they were able to identify their room with a memory box which they and their family had filled with their favourite things.

Good

Is the service responsive?

Our findings

Staff were able to describe people's care needs and this matched the information we saw in the care plans. For example, they knew to give one person some pain medicine an hour before their bath as moving them would cause pain. In addition, staff told us that some of the people were more receptive to care from care workers they knew well and so if care was refused from one care worker a different member of staff would offer to support the person.

We discussed with care workers a person who was hurting themselves in the hoist. They described how they were working with the person to make being hoisted a less traumatic experience, as they had a bad experience in another care home. For example, they now waited until after breakfast when the person was more relaxed.

Staff told us that the nurses were good at handing over any information related to people's care needs when the shifts changed over. They said this ensured that they were always up to date when people's needs changed.

Records showed people's needs were assessed before they moved into the home. This allowed the provider to be confident they could meet people's needs and develop a comprehensive care plan. Where people had given their consent family members were involved in the care planning and identifying how care could be personalised. .

We saw all the staff interacted with people living at the home and talked to them about different things that were individual to them and things they liked doing. Care workers offered people choices for activities. One relative told us that there was normally activities going on for example, games, songs and music. However, we saw activities were not always used to support people's behaviour. For example, one person was walking around and trying the emergency exit, but there was no support given to identify what was needed to help them be settled and calm.

Care plans were reviewed on a monthly basis. The review coincided with the person being 'Resident of the day.' On this day the person's care plan was reviewed with all of the home's departments such as catering and housekeeping to see if any changes to care were needed to support the person.

The provider has a central complaints process which sent an acknowledgement letter to the person and they passed the complaint the individual home. There was only one complaint recorded from which was from 2014. We saw this had been satisfactorily resolved in a timely fashion.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager who had been in post since July 2015. However, they were not registered with the Care Quality Commission. We had received an application for them to register and at the time the inspection took place this was being processed. 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 provider had failed to notify us about a number of incidents which they are required by law to tell us about. Notifications have not been received by the Care Quality Commission for safeguarding's, Deprivation of Liberty Safeguard (DoLS) approvals and they had failed to tell us if when people died they had been subject to a DoLS. We discussed this with the operations director and identified that this had occurred when the new manager came into post. They said they would ensure all notifications were submitted going forwards. We took this information into account when we rated the home.

We saw that there was a management structure in place. Staff told us that the deputy manager was good and supported them and would make changes if they raised concerns. One member of staff told us, "I can speak to the deputy they are very supportive. They are on the floor a lot and are available when needed." However, staff told us that the manager was not so supportive. They said the manager stayed in the office and they felt the manager was not always aware of what was happening in the home and so was unable to respond appropriately when they raised concerns. For example, they said that the manager had been asked more than once to order protection for a person who was hoisted and this had still not been done. They also said that the manager had failed to give them a budget for the home's Christmas party so they had been unable to plan food, games and activities for people until the last minute.

In addition morale amongst care workers was low and staff told us that they were worried that the quality of the service was declining due to staff shortages. This meant that care workers were having to pick up extra shifts to ensure that people received care. Staff told us this meant they were tired. Four members of night staff were leaving within the next four weeks and staff were concerned as only one person had so far been recruited to replace them. They did not have faith that the manager would have staff appointed and trained in time and that the responsibility for providing care would fall on them when they were already struggling to cover the daytime shifts.

Staff told us that they worked well as a team to provide care and support new members of staff. They were encouraged to attend regular team meetings where they could raise concerns. However, the feedback from staff suggested that when they did raise concerns they did not always see evidence of any changes and were not formally given an update. Staff also told us that at times they were limited in the care they could provide due to a lack of resources. For example, there was only one reclining chair and so people who were unable to sit up properly were limited in the amount of time they could spend in the communal areas as they had to share access to the chair.

The provider had systems in place to support their homes to share good practice. Managers from other locations provided support, mentoring and auditing at the home. This helped to highlight best practice and learn from it. Records showed that this information was discussed at a regional level and monitored to ensure managers were supported when needed.

The home was clean and tidy and appeared in good working order. This was reflected in the audits completed on a monthly basis. The provider had noted that the Statement of Purpose was out of date and also not on show, this was in the process of a renewal and would be displayed when finished. The provider had a central action plan which all locations used and where shortfalls in care were identified appropriate action was planned to remedy the issues. This ensured that there was a consistent national approach to the quality of care provided.

The provider encouraged people to get involved in the development of the service they received. We saw that people used to be invited to attend a residents' meeting to gather people's views on the service. However, the provider found that people did not engage with this so each person was now spoken with on an individual basis, and this was well documented. There was also evidence of relatives meetings, and staff told us that relatives could always speak to them when they were there. The provider also supported links with the local community and on the day we visited the local school came to the home to sing carols for people. We saw that people enjoyed this.

The provider had developed a 'Creative Minds' training programme which was available for all staff and staff confirmed they had completed training. The training programme has been accredited by the University of Brighton and supported staff to understand the impact of dementia on the person and family, enable positive experiences for people living with dementia, understand stress and distress reactions, and promoting dignity and respect for all those living with dementia.