Ashfield Specialist Care Limited

Ashfield Nursing 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?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 24 and 26 July 2018, and the first day was unannounced. Ashfield Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nursing care is provided at this service.

Accommodation for up to 40 people is provided over two floors in two separate units. There were 39 people using the service at the time of our inspection. Ashfield Nursing Home is designed to meet the needs of older people living with or without dementia.

The service had a registered manager at the time of our inspection visit. 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 was not available during our inspection visit.

The first day of our inspection visit was unannounced. Ashfield Nursing Home was last inspected in May 2017 and was rated as Requires Improvement. We found breaches of Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems to regularly assess and monitor the quality of care provided to people. Staff had not received training, support and supervision to enable them to carry out the duties they were employed to perform.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) Effective and Well-Led to at least Good. On this inspection, we found improvements had not been made. This is the second consecutive time the service has been rated Requires Improvement.

People were not always kept safe from the risk of acquiring infections. People's medicines were not always managed safely. There was no comprehensive system to enable the provider to review accidents and incidents. There were times when there were not enough staff to meet people's needs in a timely way. The provider had not taken steps to ensure the environment was suitable for people's needs. People were not given support to access community dental services, but were supported access other healthcare services when required.

People who needed support to communicate were not always able to meaningfully participate in making decisions about their care. People and relatives were not consistently supported to participate in planning or reviewing their care. The provider could not ensure that people, relatives and staff could meet in private, and there was a risk information about people's care would not remain confidential. Concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed.

The provider had not ensured their quality assurance system was effective in identifying issues and ensuring action was taken to improve the quality of care. The provider did not always respond to feedback from internal audits and external professionals to address areas where the quality of care was poor. The provider had not always notified CQC of significant events as they are legally required to do.

People were kept safe from the risk of abuse. The provider had ensured staff were of good character and were fit to carry out their work. Risks relating to people's assessed needs had been assessed and mitigated. People received their personal and nursing care from staff who had training to enable them to meet people's needs effectively. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

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. The provider was working in accordance with the Mental Capacity Act 2005 (MCA), and people had their rights respected in this regard. People's right to private and family lives were respected. People and relatives were supported to discuss their end of life care, and staff knew how to support people and their relatives in the way they wanted.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to these concerns found during inspection is added to reports after any representations and appeals have been concluded.

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.

People were not consistently kept safe from the risk of acquiring infections. People's medicines were not consistently managed safely. Staff we spoke with were confident about reporting concerns, and were aware of the provider's safeguarding and whistleblowing policies.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service environment had not been adapted to be suitable for people's needs, particularly for people with dementia or visual impairments. People did not have access to community dental services, and were at risk of developing oral health problems. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives were not consistently supported to participate in making decisions about planning or reviewing care. The provider could not ensure that people, relatives and staff could meet in private, and there was a risk information about people's care would not remain confidential. People and relatives were positive that staff supported them with care and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed. People had support to maintain interests and hobbies. People and relatives were supported to discuss their end of life care, and staff knew how to support people and their relatives in the way they wanted.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not ensured their quality assurance system was effective in identifying issues and ensuring action was taken to improve the quality of care. The provider did not always respond to feedback from internal audits and external professionals to address areas where the quality of care was poor.

Ashfield Nursing 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.

The inspection took place on 24 and 26 July 2018, and the first day was unannounced. The inspection visit was carried out by an inspector, a specialist advisor with experience in providing nursing for older people and people with dementia, 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. The second day of our inspection was carried out by one inspector.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about specific events which the service is required to send us by law. We sought the views of commissioners from the local authority and clinical commissioning group. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. Commissioners also undertake monitoring of the quality of services.

During the inspection visit we spoke with eight people who used the service, and six relatives. We spoke with two nurses and three care staff. We also spoke with the interim manager and provider's director, and with the registered manager employed by one of the director's other services. We sought the views of three external health and social care staff. We looked at a range of records related to how the service was managed. These included four people's care records and we looked at how medicines were managed. We also looked at two staff recruitment and training files, and the provider's quality auditing system.

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. This is information we require providers to send us to give some key information about the service, what the service does well, and improvements they plan to make. We took this into account when we made the judgements in the report. We also asked the provider to send us information about staff training, policies and audits following the inspection visit, and they did so.

Requires Improvement

Is the service safe?

Our findings

People were not consistently kept safe from the risk of acquiring infections. The upstairs food and drink area was not clean. For example, grouting on the tiles was discoloured and the wall was stained. Open foods in use were not dated or stored in appropriate containers. Containers for sugar were sticky and visibly dirty. In two of the downstairs toilets, the support bar beside the toilets was chipped, meaning it could not be cleaned effectively. In one of the two toilets, the floor skirting was coming away from the wall, which meant it could not be cleaned correctly. Several areas of the service, including people's bedrooms, were malodorous. We found a suction machine (medical device) which was dirty and not stored ready for use. This put people at risk of infection if used. Staff took immediate action to make this equipment safe during the visit, but this had not been identified as a risk prior to the inspection visit. The provider acknowledged the issues we identified, and told us they would take action to improve.

People's medicines were not consistently managed safely. People and relatives felt staff supported them or their family members to manage their medicines well. However, medicines were not consistently stored at the required temperatures. In July 2018, records showed there were 17 occasions when the room temperature was not within the acceptable range. The temperature in the room used for storage of medicines and prescribed dietary supplements was also above the recommended temperature on the first day of our inspection visit. Staff and records were not clear what action had been taken regarding this. This meant there was a risk people's medicines would not be effective because they were not kept at the right temperature. We spoke with the provider about this who said they would take action to ensure medicines were consistently stored at the correct temperature. A number of people were prescribed medicines as and when required (PRN) for pain relief. Each person's PRN care plan stated staff should use a formal assessment tool to help identify levels of pain when the person could not clearly communicate this themselves. Staff told us and records confirmed the assessment tool was not being used. This put people at risk of not receiving their pain relief medicines when they needed them. Staff took action during the inspection visit to ensure the assessment tool was now used with people who needed it. With regard to other prescribed medicines, staff told us and evidence showed these were stored, documented, administered and disposed of in accordance with current guidance and legislation.

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

Accidents and incidents were documented and action taken where necessary to reduce the risk of reoccurrence. Staff told us, and we saw records which confirmed where individual incidents were documented. These showed any action taken to reduce immediate risks and ensure people were safe. However, there was no consistent analysis to enable the provider to identify patterns or trends in poor or unsafe care provision. Staff accepted this was not being done consistently. This meant there was a risk themes relating to poor or unsafe care would not be identified.

People and relatives felt there were enough staff to meet their needs. Staff felt there were generally enough of them on each shift to meet people's needs, but said there were times when there were not, which could

impact on delivering care in a timely way. Staff also commented that the service would benefit from having two nurses on duty during the day due to the complex needs of people. Our observations at lunchtime on 24 July 2018 showed some people in the upstairs dining room waited 45 minutes from being seated to receiving their food. We noted that this waiting time unsettled people, and this led to an incident between two people. We also observed how quickly people using the staff call system waited for assistance. On one occasion, one person waited six minutes for staff to attend them, and on another staff took five minutes to respond. This showed there were not always sufficient numbers of staff to meet people's needs in a timely manner.

People said they felt safe living at the service, and relatives also felt their family members were safe. One person said, "I feel safe; the amount of care and everything I get makes me feel safe." Staff we spoke with were confident about reporting concerns, and were aware of the provider's safeguarding and whistleblowing policies. Records showed the provider reported safeguarding concerns to the local authority, who have responsibility for investigating safeguarding concerns.

Risk assessments were tailored to each person's health conditions. A relative described how their family member was assessed as being at risk of falls. They said staff ensured their family member used their bed on a low height setting with a crash mat to reduce the risk of harm if they fell from bed. Staff knew what action to take to reduce risks associated with people's needs. For example, one person was at risk of skin breakdown. Staff knew how to provide support to minimise the risks, including repositioning the person every two hours and monitoring skin health. The person's care plan reflected the staff knowledge, and records showed the person was being supported in accordance with their assessed needs.

Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. This ensured staff were of good character and were fit to carry out their work.

Requires Improvement

Is the service effective?

Our findings

At the inspection in May 2017, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staff training. On this inspection, evidence showed improvements had been made. People received care from staff who were trained and whose skills and knowledge were monitored. Staff told us, and records confirmed they had regular meetings (or supervision) with their manager to discuss their individual work performance, training or development. This meant staff could be given feedback on their skills, and where needed, be given training and support to improve their care practices. Staff said they had training as required by the provider to meet the needs of people living at the service, and records confirmed this. An external health professional also confirmed they provided additional training as and when required in relation to people's changing health needs.

All staff had a probationary period before being employed permanently, and an induction which included training and shadowing colleagues. Staff said they felt their induction and training gave them the skills to be able to meet people's needs. Nursing staff had access to revalidation with the Nursing and Midwifery Council (NMC). This process ensures nurses maintain their nursing practice and keep up to date with skills training. They must undertake a specified number of hours of training in relation to their role, including reflection and feedback from people to ensure they are safe to practise as a nurse.

The service environment had not been adapted to be suitable for people's needs, particularly for people with dementia or visual impairments. There was a lack of signage around the building to help people orientate themselves and support their independence. An information board showing the day and date was not accurate. There was limited quiet space for people downstairs, aside from their bedrooms, and several narrow corridor areas upstairs. This meant people often came into each other's personal space, and we saw several occasions where this caused people anxiety or distress. We noted throughout the inspection there were times when the service environment was very noisy, with sound from a range of sources, including staff call buzzers, televisions, the telephone system, and people vocalising loudly. Staff told us the service environment was noisy, and that this sometimes had an impact on people's behaviour or mood. Work had been carried out on the garden to make it a pleasant environment but it lacked accessibility. We saw, and staff confirmed, that people could only access the garden area with support due to uneven path surfaces. We also saw that staff used the garden seating area to smoke. The provider had started work to ensure the environment was suitable for people's needs.

Six people said they had not had access to a dentist whilst living at the service. Staff confirmed and records showed people were supported with their daily oral care, but there was no evidence people were supported to have regular dental checks. This meant people were at risk of developing oral health problems. We spoke with the provider about this, and they agreed action was needed to ensure people had access to a dentist.

People were supported by staff to access other healthcare services when required. Two people described how they were supported to see an optician and chiropodist, and a relative confirmed this was the case. Records we viewed supported this.

People and relatives were positive about the skills and knowledge of staff. One relative said, "Staff know what they are doing." Another relative said staff supported their family member well, and described how staff understood their family member's medical conditions. Staff we spoke with were knowledgeable about people's needs and preferences for how they received care.

People's needs and choices were assessed in line with current legislation and guidance in a way that helped to prevent discrimination. Assessment of people's needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans. For example, people's needs in relation to any disability or health condition were identified, and staff we spoke with were familiar with people's care plans and how to meet their needs.

People told us they enjoyed their meals, and said they were offered a good variety of meals, snacks and drinks. One person liked being able to order an alternative meal, saying, "Sometimes I just want a jacket potato and cheese, and they [staff] do that for me." Another person described how staff assisted them to eat, and said, "I get plenty of food, and they bring me drinks regularly." People were offered support and encouragement to eat where this was needed, and we saw this was done in a sensitive and dignified manner. People who needed adapted cutlery or crockery were provided with this, and this enabled them to maintain their independence when eating and drinking. Staff knew who needed additional support to eat or special diets, for example, fortified diets or appropriately textured food and thickened drinks. People who were at risk of not having enough food or drinks were assessed and monitored, and where appropriate, advice was sought from external health professionals. People were supported and encouraged to have a varied diet that gave them sufficient to eat and drink.

Staff told us and evidence showed they kept daily records of key events relating to people's care. Staff shared information with each other during the day about people's daily needs. This meant that staff knew what action was needed to ensure people received care they needed each day.

Health professionals spoke positively about communication between staff and external health and social care services. One health professional said, "Staff are not afraid to seek medical reviews for people with any health concerns." Another health professional described how quickly staff responded to people's changing health needs, and commented on one staff member being, "Really proactive."

The provider was working in accordance with the Mental Capacity Act 2005 (MCA), and people had their rights respected in this regard. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

People and their relatives confirmed staff gained permission before offering care. We saw staff took time to ask people before offering care, and tried to ensure people understood what support was being offered. Staff understood the principles of the MCA, including how to support people to make their own decisions, and they received training in this. People can only be deprived of their liberty so that they can 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. The provider had assessed people as being at risk of being deprived of their liberty and had made applications for a number of people.

Requires Improvement

Is the service caring?

Our findings

People and relatives were positive about the staff who supported them. One person said, "Staff are very nice and gentle with me." Another person described how staff were patient and caring with both them and other people living at the service. One relative said, "Staff here are absolutely amazing. They provide care, love and cuddles." A health professional said, "They [staff] provide person-centred care showing kindness and compassion and treat people with dignity and respect." Throughout our inspection visit, staff responded quickly to people's requests for support or reassurance.

People and relatives we spoke with were not clear if they had been involved in reviews of their personal or nursing care. Staff said the monthly reviews of people's care plans were not always done with people, and records confirmed this. People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. Staff were familiar with people's verbal communication styles, and encouraged people throughout the inspection to talk about how they wanted to be supported. However, the provider had not ensured people who required additional support with communication had their needs met. People and relatives were not consistently supported to participate in making decisions about planning or reviewing of their or their family member's care.

Staff and health professionals told us there was no private space for them to have confidential discussions about people's care. The office was primarily used by management and administrative staff, and we saw staff using this office were frequently disturbed by colleagues, people, relatives and other visitors. We identified with staff that, apart from the office and people's individual bedrooms, there was limited space for private conversation relating to people's care. There was a room available on the second floor for meeting purposes. However, staff and visiting health professionals working downstairs were carrying out work discussing people's care and accessing care records at the downstairs nursing station during our inspection visit. This area is in the main foyer of the building, and was not a private area where confidentiality could be assured. There was a risk information about people's care would not remain confidential.

People told us staff respected their privacy, for example, by always knocking on bedroom doors and waiting for a response. One person said staff ensured curtains and the door were closed when providing personal care to ensure their privacy and dignity were maintained. We saw staff did this throughout the inspection. However, we also saw that people's privacy in their bedrooms was sometimes interrupted by other people. For example, one person spent time moving around trying door handles and opening bedroom doors. We spoke with them, and staff confirmed the person was living with dementia, and was not aware their actions may be intrusive to others. The provider took action during the inspection visit to reduce the likelihood of people privacy being interrupted in their own bedrooms.

Staff we spoke with understood when it was appropriate to share information about people's care. Records relating to people's care were stored securely, as were records relating to the management of the service.

People were supported to spend private time with their friends and family. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting times. This showed people's right

to maintain relationships important to them were respected.

Requires Improvement

Is the service responsive?

Our findings

People and relatives knew how to raise concerns or make a complaint. Information about this was available in the home. However, records associated with managing concerns and complaints were not consistently completed. There was little evidence how complaints had been managed or resolved since 17 May 2016. For example, we were aware of a complaint about noise at the service, initially raised with the service in June 2018. Evidence shared with CQC after the inspection visit showed the provider had not arranged to discuss concerns in a timely way. Concerns and complaints were not clearly resolved. Meetings for people and relatives were held, but these were infrequent, and the last one was held on 12 April 2018. There was a risk that the views of people, relatives and staff were not sought and used to drive improvements in the service.

The provider had not taken steps to meet the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

The provider employed staff to coordinate and facilitate activities, and people said there was a range of activities to get involved in. One person described having, "Entertainment and music, and sometimes we have a singer." A relative said the activity coordinator was, "An inspiration who has transformed the activities." Staff said people could take part in both group and individual activities, and they had good knowledge about people's interests and hobbies. People had support to maintain interests and hobbies.

People using the service said how their individual needs were met. For example, one person described the support they received to practice their faith. Staff gave examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, gender, ethnicity, faith and sexual orientation. These needs were documented and all staff we spoke to knew the needs of each person well.

People and their relatives were encouraged to talk about their wishes regarding care towards the end of their lives. A health professional said, "The staff are well trained at recognising individual needs especially those at the end of life and quickly ensure all measures are put in place to make the process comfortable for both the person and their families." People had advance care plans in place which included, where appropriate, records of their wishes about resuscitation. Staff told us, and records showed they received training in end of life care. This meant people and relatives were supported to discuss their end of life care, and staff knew how to support people and their relatives in the way they wanted.

Inadequate

Is the service well-led?

Our findings

At the inspection in May 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider's system for assessing and monitoring the quality of care was not effective. On this inspection, we found the provider's quality monitoring system was still not effectively identifying areas where improvements were required.

The service was not well-led. During this inspection we identified shortfalls across all of the key questions we ask about services. This included failures in safe care practices, care that was not consistently person-centred, and concerns about how risks in the environment were managed to meet people's needs.

The provider did not have a clear strategy to deliver high-quality care and support. Although staff understood their roles and responsibilities, the provider was unable to demonstrate staff were supported to provide care that was in accordance with the provider's statement of purpose. A statement of purpose is a legally required document that includes information about a provider's service, including the provider's aims, objectives and values in providing the service. The provider had not ensured staff consistently demonstrate their stated philosophy of care at the service.

The infection prevention and control audits had not identified a number of issues we found on this inspection visit. For example, in one bathroom, the shower chair had areas of rust which prevented effective cleaning, and many taps needed descaling in other bathrooms and toilets. Medicines audits had not identified that there was no consistent guidance in relation to proton pump inhibitor (PPI) medicines. PPIs reduce the amount of acid made by the stomach, and are commonly used to treat acid reflux and ulcers of the stomach and part of the gut. There was no guidance in people's care plans to ensure they were given their PPI at the right time, for example 30 minutes before food and other medicines. Although staff we spoke with were aware of the need to give PPIs before food, there was no system in place for the provider to ensure this happened consistently in accordance with each person's prescribed medicines guidance. The provider had not ensured their quality assurance system was effective in identifying issues and ensuring action was taken to improve the quality of care.

The provider's checks and audits had not identified that there was no evidence about how complaints were being managed. There was also no clear systematic approach to ensure that the views of people, relatives and staff were used to identify issues with the quality of care and drive improvements to the service.

The provider was unable to demonstrate how they analysed accidents and incidents to look for trends. This meant there was a risk that themes of poor or unsafe care provision were not identified in a timely way.

The provider did not always respond to feedback from internal audits and external professionals to address areas where the quality of care was poor. For example, concerns about infection prevention and control measures had previously been identified in an provider action plan (dated as completed on 2 August 2017). For example, wooden boxing for piping in toilets and bathrooms were in poor condition, which meant they could not be cleaned effectively, and placed people at risk of acquiring infections. We noted on this

inspection visit that action had not been taken to remedy this. An infection prevention and control audit carried out by the clinical commissioning group on 31 July 2018 noted this was still an issue, and had been a concern at a previous audit.

The provider had not always notified CQC of significant events as they are legally required to do, and their audit process for reviewing incidents had not identified this. This was specifically in relation to allegations of abuse where people may require safeguarding from the risk of harm. For example, on 16 July 2018, one person had hit and then kicked another person. Although staff had taken appropriate action for incidents at the time, the provider had not notified CQC as required. We confirmed with staff we had not consistently received notifications. This meant the provider was not informing CQC of significant events that occurred in the service which would have assisted us to monitor the quality of care, and their processes for monitoring significant events had not identified this. The provider gave us assurance that notifications would be made in future.

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

The service had a registered manager at the time of our inspection visit. 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 was not available during our inspection visit.

People felt staff and management were approachable, and felt the service was led well. Staff felt they received support from their colleagues and management.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not consistently kept safe from the risk of acquiring infections. People's medicines were not consistently managed safely.