Askham Village Community Limited

Askham Court

Inspection report

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Date of inspection visit: 14 October 2015
Date of publication: 24/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 April and 7 May 2015. A breach of three legal requirements was found. This was because there were not always enough suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people who lived at the home. Medicines had not always been managed safely. People were not involved in planning their care and support. Care plans did not contain sufficient information for staff to deliver consistent, personalised care.

After the comprehensive inspection the provider wrote to us to tell what they would do to meet the legal requirements in relation to the breaches.

We undertook this unannounced focused inspection on 14 October 2015 to check that the provider had followed their plan and to confirm that they now met the legal requirements.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Askham Court on our website www.cqc.org.uk.

Askham Court is a registered care home that provides accommodation and care, with nursing, for up to 12 adults who have a physical disability and/or mental health needs. It is part of the Askham Village Community, which comprises of four care homes, each catering for a different client group, built around a central courtyard garden. Askham Court is a single storey building, with a large lounge/dining area and kitchenette. All bedrooms

Summary of findings

are single rooms and have an en suite bathroom. There is a shared café opening onto the courtyard, which is open to the general public. There were 11 people in residence at the time of our inspection.

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

At our focused inspection on 14 October 2015 we found that the provider had followed their plan, which they told us would be completed by 21 July 2015, and legal requirements had been met.

Staffing numbers had improved and there was evidence that there were sufficient staff on duty to meet people's care and support needs safely. Medicine management had improved so that medicines were handled safely.

An incident had occurred and the provider had failed to follow the correct reporting procedures, as required by law and by local protocols.

Improvements had been made to the care planning system. People or their relatives had been involved in planning the person's care and support to ensure that staff delivered care and support in the way the person needed and preferred. Care plans had been updated and guidance for staff improved to enable staff to deliver more consistent and personalised care. Some further improvements were still required to ensure that the care plans were fully personalised.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe

Staff had not always followed the correct procedures to report incidents and concerns to the local authority safeguarding team. This put people at an increased risk of unsafe care.

There were sufficient numbers of staff on duty to meet people's needs safely.

Is the service responsive?

Requires improvement

The service was responsive

People were involved in planning their care and support.

Care plans contained sufficient information for staff to deliver consistent care. Further improvements were required to ensure that care was fully personalised.

Whilst improvements had been made we have not revised the rating for this

key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for effective at the next comprehensive inspection.

Askham Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Askham Court on 14 October 2015. This inspection was completed to check that the improvements to meet the legal requirements planned by the provider after our comprehensive inspection on 14 April and 7 May 2015 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service responsive. This is because the service was not meeting legal requirements in relation to those questions.

The inspection was undertaken by two inspectors.

Before the inspection we looked at the information that we held about the service including information received and notifications. Notifications are information on important events that happen in the service that the provider is required to notify us about by law. We also looked at the provider's action plan which we received on 20 July 2015.

During our inspection we spoke with two people who lived at the home, three members of support staff, a nurse, the registered manager and the provider's operations and quality manager. We looked at two people's care records, records relating to the management of medicines, audits of medicines and staff rotas.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Askham Court on 14 April and 7 May 2015 people who lived at the home, their relatives, staff and external professionals all expressed concerns about the level of staffing. They gave examples of how this shortfall in the number of suitably qualified and competent staff on duty had impacted on the care received by the people who lived at the home. This meant that there were not enough staff to meet people's needs.

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

At our focused inspection on 14 October 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above.

People told us that there were enough staff. One person said, "I feel safe here, everything is perfect" and told us that staff always came quickly when they were called. Another person said, "There are enough staff on duty, no obvious shortages." They told us that staff offered them a wash or a shower every morning and that their preferences were "not limited by staffing."

Our observations showed that there were enough staff on duty to meet people's needs and support people safely. People had been ready to attend their therapy sessions throughout the morning and two people had already gone out shopping with staff when we arrived. We saw that staff were busy but that they had time to support people in a calm, unhurried way.

Staff told us that there were usually enough staff on duty. One member of staff said, "It's got better [in the last six months]. It's easier now to do our jobs and we have time to spend with people." One member of staff said, "Staffing is fine." They added that "occasionally" there had been one member of staff short but people had still received the support they needed. The registered manager told us that she had spoken with new staff after each of their shifts. She quoted one new member of staff who, the day before our inspection, had compared Askham Court with their previous employment and said, "It's lovely to have time to be able to care for the residents."

The registered manager told us, "Staffing is good, much better." They explained that a lot of new staff had been recruited and that recruitment was ongoing. On the day of our inspection there were five support staff on duty, one nurse and a new staff member who was shadowing the more experienced staff. An activities coordinator was working in the home and therapists were supporting people to use the gym. The registered manager said there had been very few occasions when staffing had dropped below this level. They stated that staff from one of the other three care homes on the site had come to assist when needed.

The provider used an assessment tool that measured people's dependency levels and calculated the number of staff required to meet those dependency levels. The registered manager told us that the assessment tool now being used was "more appropriate to rehabilitation and much more detailed, useful and reliable." We looked at the staff rotas for the two weeks before our inspection. The rotas confirmed that the provider's minimum staffing levels, as described to us by the registered manager, had been achieved.

At our comprehensive inspection of Askham Court on 14 April and 7 May 2015 we found that medicines were not always managed safely. One care plan had not been updated to inform staff that the person no longer administered their own medicines. A number of medication errors had taken place and unused medicines were not disposed of safely.

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

At our focused inspection on 14 October 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above.

Care plans we looked at had been updated to include the correct details about people's medicine administration. Staff told us that there had been no errors in the way that medicines had been given and only one error in the documentation. They showed us that detailed and thorough audits of medicines had been carried out, which had identified this documentation error and confirmed that no other errors had been found. The registered manager told us she had spoken with the member of staff who was "mortified" at this, her first medication error. Records showed that medicines had been disposed of safely and that staff had followed the correct procedures.

Requires improvement

Is the service safe?

During the inspection we found that an incident had taken place, during which a person had been left in pain for several hours as they did not receive the medical attention they needed. The provider had not reported this incident to the local authority's safeguarding team as required.

This was a breach of Regulation 13(1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection of Askham Court on 14 April and 7 May 2015 we found no evidence to show that people or their relatives had been involved in planning the person's care. The care delivered was not always based on people's preferences. Care plans did not give staff the up to date guidance and information they needed to make sure people received consistent, effective and personalised care. In some instances, where guidance had been updated and made clear, staff did not always follow the guidance.

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

At our focused inspection on 14 October 2015 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above, and improvements had been made.

People told us they knew about their care plan and one person said, "I signed a form [to agree the care planned]." In another person's care plan we saw evidence that the person's relative had been involved in planning their care.

Care plans we looked at had been updated and gave staff guidance on how to support people to meet their needs in the way the person preferred. Staff told us that they were given time to read people's care plans. One member of staff said, "The care plans are useful and contain enough information." Another told us, "The care plans are more person-centred now, more specific than before and laid out better. They give a better picture of the person." A third member of staff said, "Care plans are getting better, much more up to date, with individual information."

Staff told us there were a number of ways in which they could add information and changes to the plans. They said that communication about changes in people's care needs was very good and included verbal and written handovers as well as written changes to the care plan.

The plans guided staff on what the person could do for themselves to maintain, and sometimes improve, their independence. Staff knew people's needs well and could tell us in detail about the ways in which each person preferred their care and support to be delivered by the staff. This included a person who had been living at the home for only a few weeks.

However, we found that the plans were not as personalised as they should have been. For example, in one female's care plan it was clear another person's plan had been used as the words 'him' and 'his' appeared three times. Some details were still missing from the care plans. For example, one person's care plans gave staff a lot of detail about the care and support the person needed in relation to their catheter, but did not explain what staff should do if the catheter blocked. A recent safeguarding investigation found that for another person there had been insufficient detail to guide staff in relation to one aspect of their behaviour.

In one person's care plan we found a statement from the provider, which read, "At Askham Care Homes we value the resident's individuality through person-centred care plans." The registered manager agreed that, although the plans had been updated and contained correct and sufficient guidance for staff, there was "still a way to go" before they were fully personalised.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had failed to correctly report a potential safeguarding incident, as required by law and by local protocols.** **Regulation 13(1), (2) and (3)**