W Scott

Ashleigh House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 27 June 2017. Ashleigh House provides accommodation and personal care for up to 24 older people in the Sherwood area of Nottingham. On the day of our inspection 17 people were using the service.

At the time of our inspection there was no registered manager in post. The previous registered manager had deregistered on 1 June 2017. An acting manager was in place and the owner told us they were in the process of recruiting a registered manager. We will continue to monitor this. 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.

People could not be assured they would always be supported by sufficient amounts of staff or in a clean and hygienic environment. People were protected from the risk of abuse and that their medicines would be administered safely. Risks to people's safety were assessed and acted upon.

People were supported by staff who received training to help them carry out their roles and responsibilities effectively. Plans were in place to ensure all staff were up to date with the required training. People's right to make decisions for themselves were respected and staff acted in the best interests of those people who lacked the capacity to make their own decisions. People were supported to maintain their nutrition and healthcare.

People were cared for by staff who were caring and attentive and treated them with dignity and respect. Staff knew people well and respected their choices and preferences. People felt involved in planning their own care and had access to advocacy services if required.

People received care and support in line with their needs and preferences. People provided mixed feedback on the activities provided at the home but were supported to maintain their interests. People felt confident that any concerns or complaints they had would be responded to and records showed this to be the case.

People could not always be assured that the systems in place to monitor and improve the quality of the home were effective in identifying and addressing areas of improvement. People and staff told us the acting manager and the provider were visible, approachable and responsive to any issues. People were given the opportunity to be involved in the development of the home.

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

People could not be assured they would always be supported in a clean and hygienic environment.

People were at risk of not receiving support in a timely manner as staffing levels did not always match those identified by the provider.

People were protected from the risk of abuse and risks to people's safety were assessed and acted upon.

People were supported to take their medicines safely.

Is the service effective?

Good

Staff received training to help them carry out their roles and responsibilities effectively. Plans were in place to ensure all staff were up to date with the required training.

People's rights to make decisions for themselves were respected and staff acted in the best interests of those people who lacked the capacity to make their own decisions.

People were supported to maintain their nutrition and healthcare.

Is the service caring?

Good

People were cared for by staff who were caring and attentive and treated them with dignity and respect.

Staff knew people well and respected their choices and preferences.

People felt involved in planning their own care and had access to advocacy services if required.

Is the service responsive?

Good

People received care and support in line with their needs and preferences.

People provided mixed feedback on the activities provided at the home but were supported to maintain their interests.
People felt confident that any concerns or complaints they had would be responded to and records showed this to be the case.

Is the service well-led?

Requires Improvement

People could not always be assured that the systems in place to monitor and improve the quality of the home were effective in identifying and addressing areas of improvement.

People and staff told us the acting manager and the provider were visible, approachable and responsive to any issues.

People were given the opportunity to be involved in the development of the home.

Ashleigh House

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 27 June 2017 and was unannounced. The inspection team consisted of one inspector 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events, such as such as allegations of abuse and serious injuries, which the provider is required to send us by law. We also contacted the local authority who fund the care of some people at the service and asked them for their views. We used this information to help us to plan the inspection.

During our visit we spoke with eight people who lived at the service and the relatives of one person. We also spoke with the cook, the cleaner, a care worker, a team leader, the acting manager and a representative of the provider. We looked at the care records of three people who lived at the service, the recruitment records of three members of staff, as well as a range of records relating to the running of the service, such as audits and complaints.

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.

Requires Improvement

Is the service safe?

Our findings

People could not always be assured they were supported in a clean environment. Although none of the people we spoke with raised concerns about the cleanliness of the home, we observed that some areas of the home were not clean. For example, some of the chairs in the lounge were unclean as was the dining room floor. The cleaner told us they completed cleaning schedules when they were working in the home and other staff were responsible for cleaning when they were absent. However, this system had not proved effective in ensuring the home was clean and the risk of infection reduced. In addition, we found that some equipment and aspects of the home were difficult to clean due to the presence of rust on equipment or floors that were not sealed. An infection control audit was carried out by the provider following our visit which identified areas which needed to be addressed to reduce the risk of infection and a new cleaning schedule was implemented.

People provided mixed opinions on whether there were enough staff to provide them with timely support in relation to their needs. Most of the people we spoke with told us the home was short staffed at times. One person said, "There's not really enough (staff)", whilst another person commented "There's usually enough (staff) but been a bit short recently and I have to wait for them to come but it's not a really long wait." One person told us about the impact that staffing levels had on the care provided to them. They told us, "I have a shower every day if I can but they need more staff as we have to be taken. I only had one shower last week as they just didn't have the time."

During our visit we observed there were sufficient numbers of staff to provide a timely response to people's requests. There were additional staff employed to carry our tasks such as preparing meals and cleaning. The staff we spoke with told us that there were generally enough staff to meet people's needs in a timely way and that when two staff were on shift; the acting manager provided additional support. However, records showed that sometimes staffing levels did not match those which the acting manager had told us was required. They told us that the support of agency staff was requested to cover short term absences and sickness but records did not evidence this had always been provided. The acting manager told us they were currently recruiting for two staff vacancies within the home. As identified staffing levels required were not always maintained, there was a risk that people's need for support may not be met in a timely way.

People could be assured the provider had taken steps to protect people from staff who may not be fit and safe to support them. For example, checks had been carried out through the Disclosure and Barring Service (DBS) prior to staff commencing work at the home. The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults and are used to assist employers in making safer recruitment decisions.

People told us they felt safe at the home. One person told us, "It's a safe place really", whilst another person told us they felt safe because, "it's the community feeling and people being around me." Another person's relative also felt their relation was safe as the environment was secure.

People were supported by staff who had knowledge of the different types of abuse which may occur and

how they would respond to any allegation or incident of abuse. The staff members we spoke with were aware of the home's safeguarding procedures. They told us they were confident the acting manager would take appropriate action in relation to any concerns about people's safety. Records showed that appropriate information had been shared with the local safeguarding authority when required. The home had some information on display about how people should expect to be kept safe and records showed that safeguarding had been discussed at a meeting for people who lived at the home. This meant that procedures were effective in minimising the risk of abuse.

People were supported by staff to maintain their safety and manage risks arising from their health needs. One person told us, "They (staff) hoist me and manage well. I've had no accidents with them." Another person informed us, "I have a pressure mat so they (staff) know when I'm getting up for the loo."

There were risk assessments in people's care plans which detailed the support and equipment people required to maintain their independence and safety. For example, one person was assessed at being of risk of falls and their care plan detailed the measures in place to keep them safe, such as a sensor mat so that staff were alerted when the person was attempting to mobilise and could provide support. Another person was at risk of developing a pressure ulcer and had pressure relieving equipment in place to reduce this risk. Some people regularly left the home without staff support to access the community and public transport. People's ability to do so safely had been assessed and measures were in place to reduce risks such as people filling out a form when they left the home advising staff where they were going and when they intended to return.

Records showed that regular safety checks were carried out at the home, for example, regular testing of moving and handling equipment and fire alarms. During our visit we did identify a couple of potential safety issues, such as uneven surfaces on the ramp to the garden and the acting manager informed us of their plans to address issues or confirmed action they had taken following our visit.

People told us that their medicines were available to them and staff supported them to take their medicines safely. One person told us, "I know what my tablets are for. They always stop with me in case I choke", whilst another person commented, "They stand by me while I take my pills."

People's medicines were administered, stored and recorded safely. People's medicine administration records (MARs) had a photograph of the person to aid identification, a record of any allergies and details of the person's preferences for taking their medicines. Protocols were in place for medicines which were prescribed to be given as required. Staff recorded the medicines they had administered to people on their MARs and we found these had been completed by staff with the exception of one missed signature. We checked this persons medicines and found they had been given the medicines but it had not been signed for. The acting manager made a note of the missed signature so this could be followed up with staff. Medicines were stored securely in locked trolleys and cupboards within a locked room. The temperatures of the room and refrigerator used to store medicines was recorded daily and were within acceptable limits.

Good

Is the service effective?

Our findings

People told us they felt staff displayed appropriate knowledge and skill in meeting their needs. One person told us, "I think they (staff) seem good enough with people", whilst another person said, "They (staff) seem to know what they're doing for me."

The staff we spoke with told us they had received an induction when they commenced working at the service which involved shadowing an experienced member of staff and important information such as fire procedures. They told us that they felt confident in their role following their induction. Staff also informed us they received regular supervision and an annual appraisal during which they could discuss any training needs they had and ask questions.

The acting manager told us that most staff were up to date with the training they considered necessary to perform their roles and staff we spoke with told us they had received training relevant to their role. One staff member described the training as "sufficient" and was complimentary of the face to face training provided at the home. However, records did not reflect that staff had received all the training which the provider had identified as being mandatory. We were informed by a representative of the provider about training which had been booked following our visit to ensure that staff were able to complete their roles competently and effectively.

People told us they were given choices and made decisions about their daily care and routines. One person told us, "They (staff) will ask me before doing anything to help," whilst another person commented, "It's quite up to me what I do. No one makes me do anything really."

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.

Staff told us they had received training in the MCA. The staff we spoke with displayed an understanding of how they ensured people were as involved in decisions about their daily care as they were able. For example, one staff member spoke about providing information to a person about the support they were providing and how the person was able to let you know if they wanted anything to eat. People's care plans contained mental capacity assessments in relation to specific decisions and details of any best interest decisions made in the event people lacked capacity. This meant that people's rights under the MCA were respected.

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 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 applications to deprive people of their liberty had been made if needed. We checked the records of a person who had a DoLS authorisation in place with conditions attached. The conditions were in relation to records that needed to be kept. These records could not be found during our inspection. This meant that staff were knowledgeable about how to support people in the least restrictive way but records did not always evidence this. We brought this to the attention of the manager who told us that these would be put into place following our visit.

People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were care plans in place informing staff of how best to support the person which included information about their history, potential triggers for behaviour and how staff should respond in the least restrictive way. When we spoke with staff they displayed knowledge of people and the information contained within care plans.

People told us they enjoyed the food provided for them and gave examples of how their personal preferences and needs were catered for. One person told us, "I enjoy my meals. We get good food and have two or three choices each time. They (staff) cut mine up as I can only use one hand. They'd oblige with a snack if I ask." Another person said, "They adapt (to specific dietary needs) well. [The cook] does lunch menu things without dairy for me. I eat what I'm given and can ask for anything else too."

We observed a mealtime in the home. We saw that people were offered a choice of meal and their choices were respected. The food looked presentable and well prepared. People's individual needs were catered for. For example one person was provided with a soft meal in accordance with their needs. We saw a member of staff supported a person to eat their meal and they did so patiently and with kindness, talking to the person throughout and ensuring they had finished their mouthful before offering them more. People told us they received enough to drink and we saw that people were regularly offered tea and coffee throughout the day.

People's needs in relation to their nutrition had been assessed and care plans were in place and regularly reviewed. Personal nutrition plans provided staff with information about people's likes and dislikes and any specific dietary requirements. The staff we spoke with were aware of people's preferences and needs and people's weight was monitored to ensure they were receiving sufficient nutrition.

People were supported to maintain their health and had access to external healthcare professionals. One person told us, "A dentist and optician come periodically and I have the chiropodist most months." People and their relatives described specific healthcare professionals attending the home such as their GP, dementia support team and district nurse.

People's care plans contained details of external healthcare professionals who had input into the person's care and support. This included the GP and dementia outreach team. Staff told us they knew who to contact if they noticed changes in a person's health and records showed that referrals had been made to health professionals when people's health needs had changed.

Good

Is the service caring?

Our findings

People told us they experienced positive relationships with staff who treated them with kindness. One person told us, "They're very nice, the best. Very good and helpful," whilst another person commented, "They're always lovely and treat us as they'd like to be treated." People's relatives were also complimentary of the caring attitude and friendly approach of staff.

People were supported by staff who interacted with them in a friendly and attentive manner. For example, we observed a member of staff asking a person about their meal choice for the day and taking an interest in the person's newspaper which generated a friendly conversation. We saw that staff took the time to ensure people were comfortable and responded to people's questions and requests. For example, one person was supporting a person to get comfortable in their chair and the member of staff explained what they were doing throughout. Another person had a visual impairment and we observed staff explaining who they were as they approached.

People's care plans contained information about people's likes, dislikes and preferences. When we spoke with staff we found them to be knowledgeable about people's individual requirements. For example, one person's care plan described the clothing they liked to wear and that they liked to listen to their radio. We observed this person to be dressed in their preferred clothing and listening to the radio during our visit. We saw another person had a sensory cushion as their care plan documented they liked to feel the material as they used to knit and embroider. Staff described one person's preferences for certain meals and we found that a supply of the food they liked was kept in the kitchen and was provided when requested. This demonstrated that staff knew people well and used their knowledge of people to provide care which was supportive and positive.

People were encouraged to make decisions about the support they needed. People's care plans included information about how people communicated and what aids they required to help them understand and access information, for example whether people required glasses or would benefit from being showed meals to help them choose. People told us they felt listened to by staff and respected their decisions and wishes. One person told us, "I feel fine with them. They (staff) ask me if I'm alright and will help if I need it." Another person said, "I feel confident with them (staff) washing me all over and they do listen if I'm feeling out of sorts."

Although only one of the people we spoke with could recall having seen a copy of their care plan, most of the people we spoke with felt they had involvement in planning their own care or their family had on their behalf. It was not always clear from people's care plans whether the person had the capacity to consent to some aspects of care provision or whether their family had the authority to do so on their behalf. We discussed this with the manager who told us they would ensure that consent forms were reviewed and updated if people's capacity had changed.

People had access to advocacy services. The manager was knowledgeable about advocacy services which were available to people, including whether people required an independent representative as a result of a

DOLs authorisation. Records of a meeting held for people who lived at home recorded that advocacy had been discussed with them to ensure they knew the service was available should they need it. Advocates are trained professionals who support, enable and empower people to speak up. An advocate had visited the home to hold group sessions to help identify and concerns that people may have.

People were treated with dignity and respect by staff. People told us their privacy was respected if they chose to spend time alone, staff knocked on their bedroom doors and waited for a response before entering. When we spoke to staff they were aware of the importance of maintaining people's privacy and dignity and described how they would do so whilst providing support, for example by ensuring doors and curtains were shut before providing personal care.

Throughout our visit we observed that staff treated people with dignity and respect. We saw that staff knocked on people's bedroom doors and ensured people were covered appropriately before supporting them to move position with a hoist. The acting manager told us that people's personal space was respected and that one person who lived at the service had requested a lock on their bedroom door and this was provided.

Good

Is the service responsive?

Our findings

People we spoke with told us that staff provided the care and supported they needed and wanted. One person told us, "I feel good about my care and the way I like things to be" whilst another person said, "I'd speak up if I wasn't being treated as I'd want." People's relatives also thought that staff talked to their relation and knew their needs and how to respond to them.

The staff we spoke with were knowledgeable about the needs and preferences of the people they supported. For example, one person was at risk of developing a pressure ulcer, staff were aware of this risk and could explain how they supported them to reduce this risk. We checked the daily records for this person which showed the person was being provided with support in line with their care plan. People's care plans contained information about their preferences and how they wished to be supported by staff. We observed staff following the information provided in care plans throughout our visit. This meant that people were provided with the support they needed and in the way they preferred.

People were supported by staff who had access to information about their needs. Staff told us they found the information contained within people's care plans to be useful and that any changes in people's needs were communicated to them. The care plans we looked at contained detailed information about each person, how they should be supported and what action to take in the event of any changes. For example, one person had a history of strokes and their care plan contained information about the signs and symptoms of a stroke and what action the staff should take if they suspected a stroke. The care plans we looked at had been regularly reviewed and updated when people's needs had changed.

People were supported to maintain their independence where possible. One person commented, "I do what I can, they (staff) like me doing that" whilst another person said, "they (staff) definitely encourage me to do what I can myself." People's care plans contained information about what they were able to do for themselves and what they required support with. For example, one person's care plan described the support the person required to have a wash, including in what order the person would be supported to carry out tasks and what they were able to do for themselves.

People provided mixed feedback about the provision of activities at the home. One person told us, "I get bored at times. They do bowls and games on some days. Otherwise we watch TV." Another person commented, "They do stuff with us now and then like bowling and knitting. I watch TV or play cards and dominoes with my friend."

Staff told us they had resources available to them to provide activities such as games and quizzes and that they do try and provide activities if they have the time and people wish to join in. They told us that often a lot of people who lived at the home did not wish to join in and people's comments supported this. The acting manager told us that staff provided activities generally in the afternoon when they had time and they had developed resources and an activity file to demonstrate what activities had been provided and whether many people had participated or offered feedback.

During our visit we observed that some people were offered one to one activities or were able to pursue their own interests. We saw that one member of staff played a game with a person living at the service and another member of staff engaged with a person over a reminiscence book. Other people living at the home were able to access the community independently and did so during our visit. Another person told us although they were not able to access the community independently of staff; they were supported to do so regularly. They told us a member of staff took them to the shops and would "take me every week if I asked."

People felt confident to raise any concerns they had with the acting manager and felt these would be responded to. One person told us, "I've never had to complain really. I'd see the manager first" whilst another person said, "Just (had) little niggles that get easily sorted." Another person we spoke with told us they had made a complaint and this had been resolved to their satisfaction.

Information about how to complain and who to complain to was displayed within the service. The staff we spoke with were confident in responding to any complaints made if they were able and informing the acting manager of these. Staff were confident that the acting manager would take the appropriate action to respond to any complaints. Records of any complaints made were kept and showed he service had received one complaint within the last year which had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to assess the quality of the service were not fully effective in identifying and addressing improvements that needed to be made at the home. The acting manager told us that some audits were carried out to assess the quality of the service provided and identity any improvements. However, we could not find evidence that an infection control audit had been carried out since May 2015. Therefore issues we identified during our inspection had not been picked up and acted upon prior to our visit. A representative of the provider told us an infection control audit was carried out following our visit which had identified issues and provided a timescale within which the improvements would be made.

In addition, when actions had been identified by internal or external audits or reports, it was not always clear whether these had been addressed. For example, external risk assessments in relation to water safety had been carried out by an external agency. A number of actions were identified in the form of an action plan and these had not been marked as completed. Therefore it was difficult to identify whether the required action had been taken in response to improvements required. Another external risk assessment was carried out following our visit to determine if any actions were outstanding and to ensure the required improvements were made.

We recommend the provider considers ways to improve their quality assurance systems to support the drive for continuous improvement.

People told us the acting manager was visible within the home, approachable and helpful. One person told us, "I see [Manager] a lot. [Manager] is easy and helpful." Another person commented, "You can talk to [Manager] any time in the day."

The staff we spoke with told us they also found the acting manager to be approachable and felt supported in their role. One member of staff told us there was "always" someone they could contact if they needed advice or guidance. The staff we spoke with were confident in raising concerns and were aware of whistleblowing procedures. Another member of staff told us they felt included in the running of the home and that the acting manager had made it clear that staff could make suggestions about improvements. They told us that they felt that action was taken by the acting manager in response to their suggestions. We observed during a visit a relaxed and homely atmosphere within the home and staff communicated well with each other and the acting manager.

People told us they had attended regular meetings in the past which were an effective way to make suggestions and for concerns to get acted upon. One person told us, "They (staff) used to give us cards to fill in or have meetings but not lately," whilst another person said, "They have regular meetings to put our points across. Things get acted on then." Records showed the last meeting held for people living at the home was in January 2017. The acting manager told us they would be setting up regular meetings for people who lived at the service and we received confirmation that a meeting had been carried out following our visit. Records showed that a quality monitoring survey had been carried out in December 2016 and that all of the people who completed the survey were satisfied with the support they received at the home. This

meant that people's feedback was sought with a view to making improvements at the home.

The service did not have a registered manager at the time of our visit. An acting manager had been in place for the three months prior to our visit to provide management cover in the absence of a registered manager. The provider told us they were in the process of recruiting to the post of registered manager. The acting manager was aware of their role and responsibilities and records we looked at showed CQC had received notifications of events that had occurred at the service, such as serious injuries and safeguarding referrals. Providers are required by law of events such as these which occur.

Staff told us they were aware of what was expected of them and felt they worked well as a team. Staff meetings were held and a staff newsletter had been produced which reminded staff of certain responsibilities they had. Staff told us the owner visited the home regularly to check that people were receiving a good quality of service and to support the staff team. The acting manager and staff we spoke with told us they felt well supported by the provider who responded positively when they made suggestions or raised concerns. We also saw the provider was making resources available to update the décor in the home and records showed an ongoing maintenance plan was in place which included repairs and redecoration.