Mauricare Limited

Ashby Lodge Residential Home

Inspection report

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Wakefield
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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Ashby Lodge is a small residential care home for up to 22 people, most of whom are elderly. There were 21 people living in the home at the time of the inspection.

There was a registered manager in post. 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 home had a welcoming, friendly atmosphere and people told us they were happy and content living at Ashby Lodge. There had been some recent improvements to the décor and we were advised this work was ongoing.

People said they felt safe and there were routine safety checks carried out. Individual risk assessments for people were in place but were lacking in detail and accuracy.
Staff understood how to ensure people were safeguarded against possible abuse and they knew how to report any concerns.

People said they received their medicines on time, but we found some weaknesses in the management of medicines.

There were regular staff training and supervision opportunities, although staff's competence was not always monitored robustly.

People enjoyed the meals and the food and drink provision was suitable for people's needs.

Staff interaction with people was kind and caring and staff knew people well. People were encouraged to retain their independence.

Staff knew people's individual preferences and these were reflected in the activities provided.

Care records were not maintained with sufficient information for staff to fully understand all aspects of people's care needs.

People knew how to make a complaint and there was a system for recording complaints and compliments.

People, relatives and staff felt supported by the registered manager and they were confident their views were valued and acted upon. Systems were in place for monitoring the quality of the provision, although these were not always sufficiently robust.

The registered manager was aware of the strengths of the service and the areas to improve.

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

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

Medicines were not always managed safely.

Individual risk assessments were in place, but lacked detail.

Staffing levels were adequate to meet people's needs and staff were recruited safely.

Is the service effective?

Requires Improvement

The service was effective

Staff training was regular and sufficient to ensure staff had the necessary skills and abilities to carry out their role.

There was appropriate understanding of the legislation around people's mental capacity and the provider acted in accordance with the Mental Capacity Act 2005.

People enjoyed the food and had regular opportunities to eat and drink.

Is the service caring?

Good

The service was caring

Staff had a kind and caring approach overall.

People's dignity and privacy was regarded in the daily routine.

Staff involved and included people when they supported them with everyday care tasks. People's independence was promoted well.

Is the service responsive?

Requires Improvement

The service was not always responsive RI

Care records were not detailed or accurate enough for staff to

have full knowledge of people's care needs.

People had meaningful activities and opportunities for social interaction and staff knew each person well.

Systems were in place to record complaints and compliments about the service.

Is the service well-led?

Requires Improvement

The service was not sufficiently well led

Quality assurance systems were in place but were not fully robust to sufficiently assess and monitor the provision.

There had been a change of registered manager since the previous inspection and the new manager was aware of the strengths and areas to improve.

People, relatives and staff thought the home was well run.

Ashby Lodge Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 May 2017 and was unannounced. There were two adult social care inspectors.

We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed a poster to inform people and visitors that we were inspecting the service and inviting them to share their views.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with seven people, two care staff, the registered manager, as well as three visitors.

We looked at care documentation for five people, three recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe at Ashby Lodge. One person said, "I know they will help if I need them to". Another person said, "I need to have people round me to stay safe". One person said, "I like it here, I feel safe". Another person said, "The staff here help me stay safe, they remind me to chew my food twice so I don't choke".

Staff were aware of how to identify a safeguarding concern and the procedure to follow to ensure people were safe from harm. Staff told us they would report any concerns without delay and the registered manager demonstrated their understanding of reporting safeguarding concerns to the local authority safeguarding teams and the Care Quality Commission (CQC).

Risks to individual people were identified in their care records, although the risk assessments lacked detail and accuracy, with some information conflicting and care plans were not always detailed enough for staff to be able to mitigate the risks. For example, one person's care record stated they were at very high risk of pressure ulcers, yet there was no clear plan in place to show how this was being managed. Another person's care record stated they stored food in their mouth yet did not require any supervision at meal times.

Safety in moving and handling was sufficiently considered in practice, although care records did not always reflect what staff knew. Staff understood which people in the home required assistance with their moving and handling and there was suitable equipment available which we saw staff used safely. Where equipment was referred to in people's care records, there was not always the detail of how this should be used. For example, one person's record stated they needed to be hoisted with a cradle hoist, but there was no method recorded for staff to follow. For one person it stated they needed a bath hoist and 'full supervision' but it was not clear from the record what was meant by full supervision.

Staff were observant of people's safety and reminded people to use their walking frames where necessary. Staff were prompt in their response to one person who was coughing, to make sure they were not choking and they were supported until they felt better.

Personal Emergency Evacuation Plans (PEEPs) were recorded, although these were stored deep within people's care records and not easily accessible to refer to in an emergency.

Accidents and incidents were recorded, although some significant incidents had not been reported to the CQC. For example, we saw some accident records which showed people had been injured and gone to hospital. We discussed this with the registered manager who said they were not aware such matters needed to be reported to the CQC unless there was a very serious injury, such as a broken bone.

The maintenance staff were on duty during the inspection and attended to minor repairs around the home. They told us they made regular checks of fire safety equipment and we saw records to confirm such checks were regularly carried out. The registered manager told us the maintenance staff carried out routine maintenance and health and safety checks.

Staff were robustly recruited to ensure people were cared for by those with the relevant skills to do so. For example, we looked at three staff files and found information in the interview notes to show their experience, skills and abilities had been checked. Disclosure and Barring Service (DBS) checks had been obtained as well as references to assess their suitability. The registered manager told us there was a low staff turnover in the home, although there was a new vacancy for an activity coordinator.

Staffing levels in the home were suitable to meet the needs of the people and staff, people and relatives we spoke with said they felt there were enough staff. Staff told us the registered manager was involved with people's care and assisted care staff when necessary. Staff rotas confirmed there were consistent numbers of staff on duty. The registered manager told us they had recently created a 'sleeping' staff post for the night shift, so an additional member of staff was on site and could be summoned to help if an emergency occurred, such as a fire or a hospital admission.

We found medicines were not always managed safely. Medicines were not always appropriately stored, administered and disposed of and procedures were not being followed in line with good practice guidelines. Daily storage temperatures were not regularly checked and we found the room temperature where medicines were stored was very hot. There were weaknesses in the disposal of old medicines and the booking in of controlled drugs. The manager sent copies of records after the inspection. However, these records were not consistently recorded daily and there were gaps in the recording. Records showed over a four month period the room temperature exceeded 25 degrees on 24 days and the refrigerator temperature exceeded eight degrees on seven occasions. There was no evidence of action taken about this.

Before people were given their medicines, staff consulted with them and asked if they wanted to take them and discussed whether they had any pain. We saw staff were patient and waited until each person had taken their medicine before moving on to support another person. Details of medicines given were documented on the medicines administration records (MARs) but there was no accurate detail of the time recorded when medicines were time specific. We found one person's medicine contained a warning note to read the detailed information, yet this information was not available.

Where some people required medicines only when needed (PRN) rather than at set times, the protocols for these were inconsistent and only in place for paracetamol. We discussed with the registered manager the documentation around PRN medicines needed to be made clearer to minimise the risk of errors being made. We also saw weaknesses in the application and recording of topical creams; these were not recorded on a body map to indicate where these needed to be applied and staff we spoke with said they 'just knew' where to apply creams and the information was written on the box. Some topical creams we looked at did not refer to the date they were opened
We found the above examples meant there was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12, safe management of medicines.

Staff had access to a suitable supply of personal protective equipment (PPE) and we saw this was used appropriately. We found staff understood their role and what was involved in minimising the risk of infection. Where people needed a sling to hoist them, these were allocated on an individual basis to minimise the risk of infection. There were no malodours in the home and we saw the domestic staff regularly used air fresheners, although at times this was overpowering.

Requires Improvement

Is the service effective?

Our findings

People told us staff were competent to do their work. One person said: "They do a good job these lasses ". Another person said: "Oh they always know what they're doing". One relative said the staff were skilled in caring for their family member. They told us, "They have the skills, it's not easy work".

Staff had an induction checklist in their file which was completed. Staff we spoke with said they felt they had appropriate support for training to support them to care for people. The registered manager told us all staff were working towards the Care Certificate. Records showed staff training was completed to ensure people were cared for by staff with suitable skills to do so. Training was ongoing and we saw notices in staff areas about forthcoming training such as dementia awareness. The registered manager told us they had not yet begun to carry out formal competency checks of staff practice but said this was something they had scheduled to commence. They said, and staff confirmed they worked alongside staff in the delivery of people's care, which enabled them to keep in touch with people and observe staff practice.

We saw evidence staff had engaged in supervision meetings with the registered manager and staff we spoke with said they had regular supervision to support them in their work. The registered manager said supervisions were quarterly. Staff we spoke with said they felt the registered manager supported them in their work by being involved in people's care. The registered manager told us they enjoyed being involved in care and when time allowed they joined in with whatever needed to be done.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us people had authorised DoLS in place and there were further requests made.

We found there was a basic understanding of the legislation around people's mental capacity. Staff were aware to seek people's consent to care and where people lacked capacity, to ensure decisions were discussed and agreed in the person's best interests. Staff we spoke with had some knowledge of individual people's mental capacity and although the registered manager was clear, although not all staff knew who had authorised DoLS and why they were requested. We saw from training records staff had received training in mental capacity and the registered manager told us they worked closely with the local authority to ensure appropriate safeguards were in place. However, care records were inconsistent in their recording of people's mental capacity and some were not updated since 2015.

People said they enjoyed the meals and we saw the food was well presented and in suitable quantities for

people. People were invited to the tables, which were appropriately set and they sat together sociably to eat their meals. Staff asked people what they wanted to eat and drink and visual choices were offered to help them decide. Where people needed support to eat their meals staff assisted them and if people chose to remain in their room at mealtimes this was facilitated.

We spoke with the cook who was aware of people's individual needs, their likes and dislikes and people's choices. We heard people being asked what they would like to eat. We looked at the menus which included nutritionally balanced choices.

People were offered appropriate support and encouragement to eat and drink and staff gave reminders throughout the day. Staff told us if people were hungry in between mealtimes, provision was made to offer a range of snacks according to people's choice. We saw drinks were readily available and replenished as well as hot drinks on the tea trolley which staff brought round.

One person said, "I always enjoy my food, the meals here are quite good". Another person said, "The meals are very satisfactory all round".
The registered manager knew the nutritional risks for people and said people were referred to the speech and language therapy team (SALT) or dietician as appropriate. The care staff were aware of the people who had lost weight and who needed encouragement to eat. Where records showed people had lost weight there was evidence they were encouraged to eat more, but this was not always reflected in the care plan. Food and fluid charts were used, although we found these lacked detail. For example, food charts stated if a person had eaten all, half or a quarter of their meal, but there was no indication of the starting quantity to be able to gauge how much had been eaten. We found these were not followed up if records were not filled in.

Other professionals had been consulted about people's care and health needs and details were recorded on people's care plans. Staff we spoke with told us they would be able to identify areas of health concern, such as pressure care concerns and would involve the district nurse without delay. In people's care records we saw people's routine health care appointments were noted, such as chiropody appointments, GP reviews and eye tests.

We saw people freely accessed all parts of the home as they wished, although we noticed only one of the two lounges was used. We spoke with the registered manager who said they were considering ways in which the other lounge could be utilised more. One relative we spoke with said the home would benefit from greater use of this space as an alternative to the main lounge.

Good

Is the service caring?

Our findings

People and relatives said the staff were kind and caring. One person said: "They're lovely to me". Another person said "We are very well cared for". One relative said: "It's friendly and homely, that's what I like about the place". Another relative said, "The care here is genuine, it's not a front. Staff go the extra mile and they look after not only my relative, but the whole family, they genuinely do care".

We saw staff interacted with people in a caring and patient way, with humour and friendly banter used appropriately. One member of staff joked with a person about their singing being infectious and they laughed together. People spontaneously hugged staff and one person said, "I love you" to which staff responded with warmth and affection.

There were good relationships between people and staff on the whole and when people needed additional reassurance staff noticed and supported them with kind words. When one person became anxious staff supported them by going for a walk around the garden. Staff used gentle tones of voice and a friendly manner when interacting with people, which helped people to feel settled and at ease. However, we saw one member of staff was less skilled at interacting with people, particularly those who were living with dementia and did not always respond to reassure or engage effectively. The registered manager told us they were aware and monitoring this.
It was clear from our discussion with staff and our observation of their relationships with people, they knew people well and understood what mattered to them. Staff spoke with people about their relatives and who would be coming to visit them.

People were discreetly consulted when staff offered support with their personal care. Staff gave explanations and made sure people's choices were respected, such as whether they wished to sit to the table, which chair they would like to sit in and if they needed help. Staff knocked on doors to people's rooms and to bathrooms before being invited to enter.

All staff we spoke with said they would be happy for their own relative to be cared for at Ashby Lodge. One member of staff said: "It's like a big family, this is their home".

People's privacy and dignity was promoted in the routine of the day and staff encouraged people's independence in everyday tasks. For example, we saw one person preferred to use the stairs to go to their room and staff supported their choice, reassuring them to take their time. We saw people were encouraged to walk to the dining room for their meals and staff enabled them to move at their own pace without feeling rushed.

Care records detailed people's personal preferences, their cultural and spiritual needs and their social histories, although there was little about people's end of life wishes. Staff we spoke with said they were aware of the individual needs of people.

Requires Improvement

Is the service responsive?

Our findings

People told us they enjoyed the activities and they did not feel bored. One person told us they liked to walk to the shops and another said they liked to read the newspaper. One person said they liked their fingernails painting and we saw staff did this for them. One person showed us their jigsaw puzzles and said they liked to do these from time to time. Another person told us they had recently celebrated their birthday in the home and staff sang happy birthday to them. We saw photographs of activities people had been involved in at other times and these showed people smiling and happily engaged in activities such as dancing, baking and planting.

We saw one member of staff engaged people in a group activity of throwing and catching an inflatable ball, which people seemed to enjoy. We observed the lounge areas were frequently attended by staff and people sat chatting with one another or with staff, although there was less interaction during the morning. We saw the television played a film and some people were watching this, then later in the day some relatives watched a game show in the lounge with people who lived there.
People spontaneously burst into song, such as in the dining room and this caused others to join in. We heard a rendition of 'The Sound of Music' and staff sang along too, praising people for their singing abilities. Relatives we spoke with said they felt the homeliness of Ashby Lodge was a key feature in helping their family members choose where to live.

When staff attended to people's physical care needs they engaged in conversation and it was clear staff knew people well by the things they spoke with them about, such as naming their family members and knowing when they would be coming to see them. Staff involved people as much as possible by encouraging them to participate in their own care tasks. For example, when assisting a person with transferring with a stand aid, staff gave clear instructions about where the person should place their hands and feet and this was done in a friendly way with appropriate humour when the person got the giggles.

We looked at five care records but found these lacked detail and some aspects of the information were not accurate or contradicted other information in the files. For example, there was out of date information as well as current information and it was difficult to see which was the most relevant. Where daily records were needed, such as for regular checks of people in their room, we found these had gaps in the recording. Where care records were updated monthly, there were frequent entries that stated 'no change to care plan' without accurate review. We discussed the findings with the registered manager who told us they were aware improvements to the care records were needed and they had begun to address this process.

Care practice was more person centred than the records; staff knew people individually and what mattered to them. Staff we spoke with said care was based around individual needs. For example, people could have a bath or shower when they requested one and did not have to wait for a 'set day'. People we spoke with confirmed they 'just had to ask' the staff for support with this if they needed to and they were confident staff would enable them to bath or shower when they wanted to.

People said they saw the registered manager frequently and felt able to approach them at any time with any

concerns. One person said "I'd say if there was something I wasn't happy about but I've no need to complain". The registered manager told us they preferred to keep the office door open so anyone could come in at any time. We saw people and relatives freely approached the registered manager in their office, through their open door. Relatives told us there were residents' and relatives' meetings held regularly as well as newsletters which shared key information.

Complaints and compliments were recorded and the registered manager told us all information was taken seriously. There had been only one minor complaint received and the registered manager had responded appropriately. Compliments in the form of thank you cards and letters were displayed.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff said the home was well run and they knew who the registered manager was. One person said "We know who's in charge in this place" . Another person pointed to the registered manager and said "That's the boss". One relative said "It's good, we find it runs well and if we need to know anything we are always kept informed". Relatives we spoke with said they could not think of how things could be improved in the way the home was run.

There was a new registered manager in post since the previous inspection and people, staff and visitors told us they were visible and involved in the service. One visitor said the registered manager knew the people who lived there well and was approachable and available to discuss matters when needed. Staff said the home was run well by the new registered manager. One member of staff said "[They] have a heart of gold. This home is much better than before, we work as a team and it runs well". Another member of staff said the registered manager 'is really fair'.

The registered manager told us they saw the provider regularly and had contact numbers for the provider and the provider's other home managers if needed for support. The registered manager said they felt appropriately supported to carry out their role and were confident to raise any matters with the provider to ensure people received quality care. Staff we spoke with said they saw the provider less frequently but knew they visited the home.

Documentation relevant to premises safety checks, such as fire equipment and fire exits, were in place. Policies and procedures were reviewed and updated as required.

Handover records showed people's care needs had been discussed in detail between shifts. The registered manager had oversight of the quality of the service although the systems in place were not always robust enough to identify areas in need of improvement and take action to drive the improvement. For example, audits around the management of medicines lacked rigour, as did the audits around the quality of documentation for people's care, both areas in which we identified weaknesses at this inspection.

This meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014, good governance.

The registered manager said they carried out a daily walk around in the home, although this was not documented and we identified some aspects of wear and tear, such as worn pillows, no lock on a bathroom door and a sharp edge on the stair lift. Where we shared our observations with the registered manager they took immediate action to address the matters raised. For example, we shared concerns there was no system in place for evacuating people in an emergency and the registered manager took prompt steps to seek advice and obtain emergency evacuation equipment. There was no evidence of the manager's daily walk round at the time of the inspection, although the manager sent a copy of records to show this afterwards. We saw this did not show which areas had been checked and there were gaps in the dates recorded.

We saw there were ongoing improvements to update the decoration in the home and obtain new furniture, which the registered manager told us was part of a continuous programme; as bedrooms became empty they were redecorated.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for the management of medicines were not always safely implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for assessing, monitoring and improving the quality of the service were not robust. Records relating to people's care were not always up to date or accurate.