Circa Care Limited

Ashfield Residential Care Home

Inspection report

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London
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 September 2016 and was unannounced. At previous inspections the service met all the standards inspected.

The service is a small, owner run residential care home providing accommodation and personal care for up to fifteen older people, some of whom were living with dementia.

There was a registered manager at the service. 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.

Although there was some good areas of practice by the home, in particular the care of frailer people who remained in bed, there were some areas as described below that required improvement in terms of choice and personalisation.

The service was not always working in line with the Mental Capacity Act 2005 as they were not undertaking mental capacity assessments and best interest meetings when people lacked capacity. In addition they had not always applied for Deprivation of Liberty Safeguards appropriately. This was a breach of regulations.

People living at the service were supported to eat and drink healthily. People's care plans gave a brief indication about what food people might like or dislike. However people told us they were not offered a choice of menu and would prefer different meals on some occasions. We saw that whilst the service offered dietary alternatives there was not a choice of meals offered to people on a daily basis. People had care plans that covered a range of support needs, however sometimes they lacked detail and were not personalised enough. In particular the service offered limited choices around showering and bathing. The lack of personalised choice in meals and bathing was a breach of the regulations.

There were enough staff to keep people safe and recruitment processes were robust to ensure people living in the service were safe. Staff received training to support them to undertake their role. Staff could tell us how they would report safeguarding adult concerns and the service was reporting possible concerns in an appropriate manner. People had risk assessments to protect them from harm.

People received their medicines on time and staff administering medicines understood what the medicines were prescribed to treat. People were asked if they were in pain and were offered pain relief in line with guidelines. Medicines were stored in an appropriate manner. People received good support from staff to access appropriate health services such as the GP and district nursing service. Staff had received training to enable them to respond well in emergency. The service offered a good standard of care for people who were looked after in bed, for example, people were turned on a regular basis to avoid pressure ulcers developing.

Overall, everyone thought the staff were good or very good in terms of being caring, but there were some negative comments made by one person that we shared with the registered manager. We saw care being provided in a sensitive manner during our visit.

People expressed a gender preference when being supported with personal care and this was adhered to; some people were supported with their religious diversity needs. Some people had keys to their rooms and staff respected people's privacy and kept their information in a confidential manner.

The service was well led by the experienced registered manager who was supported by the owner and senior care staff. Staff told us they could raise any concerns and there were regular staff and resident meetings. The service was audited on a regular basis and surveys were undertaken to assure the quality of the service given.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 and Regulation 11.

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?

Good

The service was safe. The registered manager and staff understood their responsibilities under safeguarding adult legislation to report abuse concerns.

People had risk assessments to prevent injury from hazards and to give guidance to staff.

The service had safe recruitment procedures and had enough staff to meet people's needs.

Medicines were stored and administered appropriately by staff who had received medicines training.

The service was clean, well maintained and free from malodour.

Is the service effective?

Requires Improvement

The service was not consistently effective. The service was not always working under the Mental Capacity Act 2005. There were no mental capacity assessments or best interest meetings undertaken. In addition some people living at the service required Deprivation of Liberty Safeguards applications to be made on their behalf to the appropriate statutory body.

People were supported to eat and drink appropriately but people told us they did not have the choice they would like with regard to their meals.

Staff received supervision, training and guidance from the registered manager to support them in their role.

Staff were knowledgeable about people's health support needs and ensured people were supported to access appropriate health care.

Is the service caring?

Good

The service was caring. Most people said staff were caring or very caring.

People were supported with their diversity needs.

People and their relatives were involved in their care planning, including end of life planning.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans contained information about people but they were sometimes brief and did not reflect people's wishes accurately or in a detailed manner. People did not always have showers as often as they would have liked.

People and relatives were supported to make complaints and complaints were addressed appropriately.

Is the service well-led?

Good

The service was well-led. People, relatives and staff said the registered manager was approachable and addressed any concerns speedily.

There were clear lines of communication in the service to ensure all staff were kept well informed.

There were regular surveys and the results were analysed and acted on.

Ashfield Residential Care 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 22 September 2016 and was unannounced.

Prior to the inspection, we considered information we held on our database about the service and provider. We had requested an information return form from the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. However, this had not been received. The registered manager explained they had attempted to send this to us electronically however we did not receive notification as it had failed to send.

The inspection team consisted of a social care 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.

There were fourteen people using the service at the time of inspection and we spoke with six of them and observed staff interaction with people. We looked at four people's care plans and associated records such as risk assessments. We observed medicines administration and looked at six people's medicines administration records. We looked at five staff personnel records which included recruitment, supervision and training documents. We spoke with three support staff, the chef, the registered manager and the owner.

Following the inspection we spoke with three people's family members and the commissioning body.

Good

Is the service safe?

Our findings

We asked people if they felt safe at the service, one person told us, "Yes, there's no reason to feel otherwise." Another told us, "Yes we do like it here. Most of the people do keep an eye on things, yes, definitely."

Staff told us, "It is my duty to take care of the residents," explaining they would report safeguarding adult concerns to the registered manager. Staff had received safeguarding adults training. The registered manager and staff understood their responsibilities to report safeguarding adults concerns and could describe possible signs of adult abuse. We saw that the service had reported concerns to the appropriate body in a timely manner. There was a safeguarding adults policy with guidance for staff to follow and a leaflet displayed to support people to report any concerns.

Risk assessments and reviews were undertaken to ensure people's safety from hazards. Risk assessments included falling, moving and handling, isolation, and the use of bedrails. Staff reviewed risk assessments and updated them on a regular basis. People had personal emergency evacuation plans; these were brief and did not always rate risk appropriately. For example, one person who remained in bed at all times and required two staff to transfer them by a hoist as they could not weight bear, was classified as a medium risk. Although actions to address the risk were adequate the person was unable to evacuate without two staff, as such the risk to them would be high. The registered manager agreed to look at the plans and ensure the wording was explicit in each plan.

The owner risk assessed the environment and reviewed annually. There was a fire action plan in the event of a fire, fire prevention equipment and weekly fire alarm testing. The procedure for evacuation was displayed in a communal area for reference. Utilities and equipment had been tested to ensure their safety, for example, gas systems, the electrical appliances, lighting, the staff call system, and the moving and handling equipment.

Relatives told us some established staff had left recently and people were getting used to the new staff. They thought there were "probably enough staff" and "there is always a staff member nearby to talk to when we visit." One relative thought there were enough staff as their relative always looked well cared for. The registered manager explained that some established staff had returned to the nursing profession and so they had recruited into their posts.

On the day of inspection there were two staff on duty and the registered manager in the morning when we arrived. The two staff worked through the day, one until 6:00PM and one until 21:00PM with breaks. A third staff member came on duty in the afternoon and also worked into the evening until the two night staff came on duty. Staff told us they undertook both care and some cleaning duties. We had confirmation following our visit a cleaning staff member had been employed for 35 hours a week this would mean care staff would no longer be required to undertake cleaning duties.

People who wished to be up were dressed and were eating or had finished their breakfast. We noted that people who had stayed in their bedrooms had received their breakfast prior to our visit and were washed

and comfortable. One person told us, "I press the bell when I need to and it varies, sometimes it takes a long time." We noted call bells did ring throughout the service and most were answered speedily, although one did take longer at a busy time. The registered manager told us that they go and ring bells to check staff response times periodically and support if a bell has rung and not been answered quickly. They also discuss with staff to ensure there are enough staff to respond in a timely manner.

There were safe recruitment processes in place. Staff were asked to provide proof of identification, address, and two references. Before their post commenced Disclosure and Barring Service (DBS) checks took place to ensure they were safe to work with vulnerable adults. We found record of one DBS had not been kept, however the DBS had been applied for several years before and there was communication about it. The registered manager confirmed they had seen the certificate before the person commenced work. We discussed the importance of recording the DBS reference number or keeping a photo copy of the front page for future reference. The registered manager said this had been an oversight. The registered manager explained she interviewed prospective staff carefully to look at their experience and qualifications and had a trial period to ensure that they had "the heart for this work and a passion for caring".

Staff administering medicines had received medicines training. One person told us they were confident about their daily medicine being given to them on time. The service had systems in place for the safe administration and storage of medicines. The medicines were blister packed and colour coded to indicate the time of day the medicine was administered. We observed medicines administration and checked people's medicines administration records (MAR). We found that people's MAR contained no gaps or errors and medicines we counted tallied with the MAR. People's MAR contained a photo for identification and reminders for staff to check people's allergies. Where medicines were administered once a week or if dosage varied throughout the week it was clearly indicated and completed appropriately. We observed staff asking people if they were in pain and if they required pain relief. Medicines were stored securely at an appropriate recorded temperature.

The service was clean, well maintained and free from malodour. Support staff undertook cleaning duties and had received health and safety training. Posters were displayed to remind staff to wash their hands thoroughly; paper towels and hand wash were available in each toilet. Staff used disposable protective equipment such as gloves and aprons to avoid cross infection.

Staff and the chef had received food hygiene training. We saw food such as meat and poultry were stored appropriately to avoid cross contamination. Fridge temperatures were recorded daily to ensure food was stored at the correct temperature. The chef demonstrated they used colour coded chopping boards to avoid cross contamination.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they gave people choice, giving examples such as people choosing to stay in bed or choosing what clothes to wear. However, there were no written consent forms in people's records and no mental capacity assessments and best interest meetings undertaken when people may lack capacity. For example, several people told us that they did not have access to their money, such as, "I've asked for my money and they said I can't have it." Another person told us, "I would like to have my own money." Some people did not have capacity to manage their own finances and relatives had Lasting Power of Attorney to manage money on their behalf. However, there was no mental capacity assessment to establish if people could or could not manage to hold a limited amount of money or make the decision to buy small items such as sweets.

Staff told us, "The residents have freedom, they are not restricted, they can walk around the service or the garden or people can stay in their room if they want to. People who are prevented from going out by themselves and lack capacity to agree to the care and treatment must have Deprivation of Liberty Safeguards applied for. People who were requesting to go out but did not have capacity to make that choice had DoLS applications applied for appropriately by the service.

However there were a number of people who no longer had the capacity to make decisions with regard to their care and treatment but were not actively asking to leave the service. For example, one person remained in bed at all times, had bed rails in place for their safety and their care plan stated under the heading 'Communication,' "can't make an informed decision." We spoke with the registered manager who explained they had attended recent MCA and DoLS training and were now aware that they should have made DoLS applications for these people. Following the inspection the registered manager confirmed DoLS applications were in progress and mental capacity assessments would be undertaken with best interests meetings where appropriate to identify the least restrictive options for people.

This is a breach of Regulation 11 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

All people we spoke with were not happy with the meals served and said there was a lack of choice. "We don't really get a choice. They put food on a plate" and "I'm not allowed to say what I want for lunch they just bring it to me." People expressed a wish for dishes that was "a roast" or "a piece of fish" and different

vegetables to carrots and peas that were frequently served. The menu displayed contained two choices each day across two weeks. The choices were alternated each week so for example on the day of inspection there was a fish pie in white sauce with peas and carrots. Next week the other dish named would be served such as a 'hot pot with vegetables.' People did say however they liked the chef's deserts. One person told us there was no menu, however there was a menu laminated on the wall but it contained the alternating weekly menu information so it was not clear what would be served on that day. A black board was completed before lunch with the menu for the day but this was not written clearly and not easily read by someone with a cognitive impairment. Although people's care plans gave an account of some foods they liked to eat, for example "traditional English food" there was no evidence of a choice of meals being given on a daily basis.
This is a breach of Regulation 9 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

Food portions were adequate on the day of inspection and a person who requested more was given a second portion. People were offered drinks throughout the day and someone who likes biscuits with their medicines were served these. The chef and staff could tell us about people's dietary preferences naming one person who ate a vegetarian diet and people who required a soft (mashed) diet. These people were catered for and people who required support to eat were supported by a staff member in an appropriate manner.

Staff received training to support them to undertake their role. Staff told us they had completed an induction before commencing their post. We saw there was a structured induction process that covered relevant topics including safeguarding adults and medicine administration. A more recently recruited staff member told us "The manager is always very supportive, sometimes she sat with me and told me how to work with each resident, telling me about them." Staff told us and we saw from the training matrix they received mandatory training refreshers every year. These covered areas such as dementia, food hygiene, safeguarding adults, health and safety awareness and manual handing. In addition staff had also received training such as first aid, basic life support and fire safety at work to act appropriately in emergency. Some senior support staff had nursing qualifications, although they were not working in a nursing capacity, and some staff had nationally recognised qualifications in health and social care.

Staff received supervision to support them in their role. Staff told us they received regular supervision sessions and they found these sessions supportive. The registered manager explained she used supervision sessions to provide support, identify training needs and address any poor practice. She also used a knowledge questionnaire to ensure staff were aware of the procedures, this included for example infection control and what do if someone had a fall.

All staff spoken with knew people's support needs well. A staff member was able to tell us about people's support needs, physical ability, mental capacity and communication in detail when we asked them. People were supported to access health services in a timely manner. During our visit we observed the staff take the appropriate action when someone was unwell. They had called the GP and arranged a visit prior to our arrival. Staff continued to monitor the situation speaking with the person at regular intervals and discussed the option to call the emergency services. The registered manager spoke with the emergency services for advice and the person was supported to hospital by the ambulance service.

One person's relative told us their family member had remained in bed for a long period and had received good care and had not developed pressure areas. When they visited they were laying in different positions, as staff had supported them to turn on a regular basis. We saw that people were assessed for their tissue viability and there was clear guidelines for staff to follow. Turning charts were completed to show when people were turned and to what position. A district nurse visited two people during our visit. People had nutritional risk assessments and their weight was recorded. We saw referrals were made to the GP should

people's weight decrease and become a concern.

The service was situated in a residential road close to local amenities. There was a lift to all floors and areas were accessible by wheelchair. Most bedrooms were single with ensuite toilets. There was a well-used small lounge and dining area where people said they liked to watch TV and sit overlooking the well-maintained garden. There was another bigger lounge at the front of the building containing a TV and comfortable chairs. We were told some people liked to sit there as it was quieter.

Good

Is the service caring?

Our findings

Everyone thought the staff were good or very good in terms of being caring. People told us, "Yes, they (staff) do a good job" and "on the whole they are friendly and caring." People also spoke fondly of the chef as well as the support staff. However one person made some negative comments that indicated some staff might be too abrupt in their interactions. We raised this with the registered manager who agreed to monitor and address any poor practice.

Relatives commented favourably about staff. One relative said, "Staff are excellent" and that they "could not find fault with anyone." Staff told us, "I try to have a conversation, sit down and talk, I ask them do they feel well? Do they want something?" Another staff member told us, "We talk with them, communicate, it is the small things that make the difference to people, we do our best to provide what they want, people are unique, they want different things." During our visit staff were caring in their interactions with people, for example one person was supported in a sensitive manner by two staff who took time and gave encouragement. We saw other staff responding to requests in a friendly and positive manner.

Staff told us they followed people's care plans and these are updated at staff meetings. All relatives we spoke with told us they had been involved in the initial assessment and care planning. One relative described they continued to be actively involved in care planning and any changes. One relative had not had recent involvement in care planning but said they were always kept informed of changes of circumstances and asked their opinion. Most of the care plans we saw were signed by people's relatives to show their involvement.

Staff described to us that they met people's diversity needs giving examples that several people preferred to be attended by female care staff and this was adhered to and specified in people's care plans. People's care plans named their religion, for example Church of England. Some people were Roman Catholic and a priest visited to give Holy Communion. One person was supported to have a vegetarian diet and another person's relative brought in culturally specific food that they enjoyed.

Staff told us they respected people's privacy, describing they waited and closed the door to give people privacy during personal care and "knock on all doors before entering." Some people had keys to their bedrooms for their privacy and to prevent others going into their room by mistake. People told us some staff knocked and listened before entering. Staff kept records in a confidential manner and demonstrated to us they understood the need to only share people's information where necessary.

People's end of life wishes were in their care plans stating for example they wanted a "natural death", "to be resuscitated" or their "relatives contacted". People also had DNAR (Do not attempt resuscitation) where appropriate in the event of a medical emergency.

Requires Improvement

Is the service responsive?

Our findings

All people had care plans that had been updated and reviewed on a regular basis. They were easily accessible for staff to read and find information they required. Care plans covered a range of domains such as diagnosis, history, communication and support needs. All care plans contained essential information but some were brief, in particular when describing people's personal history and likes and dislikes.

People were clean and tidy at the service and were supported with body washes each day. However we were concerned that people were not being supported to have personal care as they would wish to. All care plans we looked at specified that people wanted a bath or shower once a week. Staff told us people had a "shower a week, nobody wants a bath." One person told us how they missed the opportunity to shower every day. "They come to help me with a shower or body wash daily and at night" and said that there was a booking system for having a shower and hair wash once a week. There was a 'bath book' that recorded when people were supported to shower on a weekly basis. The registered manager assured us that some people were supported to shower daily when they wanted to and that it was not just once a week. People's care plans were not detailed enough and needed to reflect people's bathing preferences clearly in a personalised manner.

This is a breach of Regulation 9 of the Health and Social Act 2008 (Regulated Activities) Regulation 2014.

People living in the service chatted to each other and looked relaxed in the lounge area. One person told us they liked to sit near the window to look at the small pots of plants on the outside ledge. There was conversation with staff and we saw cards being played with one person who enjoyed this activity. Music was played at breakfast and lunch time that people seemed to like. Two people had a conversation about whether or not the singer was Frank Sinatra and how lovely his voice was. Staff told us that people liked to read their newspapers and that they "did people's nails" as an activity which people enjoyed. Staff told us, "Professional activities take place every Friday, physical, using balls and music." Some people said they enjoyed this. People we met who stayed in their rooms confirmed they liked to do this and this was their choice. One person said they liked to read books in their bedroom explaining a relative brought books for them to read. Although some activities were taking place however they were limited and did not offer a varied choice.

One person said that they would really enjoy going on an outing. A number of people talked about how they had not gone out for a long while and would like to buy some items like sweets or presents. We discussed with the registered manager that whilst some activities were available they were limited and that some work should be undertaken with the people living in the service to understand what other activities they might enjoy. The registered manager told us they would explore this further with people.

The service had systems in place to address complaints. People and relatives said they could raise complaints if they wanted to. There was a complaints procedure and policy and a leaflet provided to tell

people how to make a complaint and what response to expect. One relative told us when they had raised concerns they were addressed in a timely and appropriate manner. The registered manager showed us examples when they had responded to a complaint, for example, an item of clothing damaged by washing was replaced by the service.

Good

Is the service well-led?

Our findings

A staff member told us the registered manager was "very supportive for everything." All staff spoken with found the registered manager very supportive and approachable. A staff member told us that "if there were any issues, they would talk to the manager to find solutions together."

There were good lines of communication in the service. The owner and the registered manager told us they met at least weekly to share information about the service and discuss any concerns. They also covered 'on call' for out of hours assistance to staff in emergency. There were daily handovers between the registered manager and staff, and the shift coming on duty. Information was shared in a communications book and diary. We saw that the registered manager addressed poor practice in supervision. There were staff meetings every four to six weeks, this was confirmed by staff as helpful in keeping them informed and giving an opportunity to discuss any issues with the staff team.

The registered manager had started working at the service as a senior care worker and had progressed to become the registered manager. They told us the owner was supportive to staff and encouraged them to reach their full potential. One staff told us "There is a good and friendly spirit to work here" describing how they were recently promoted. Staff told us they were encouraged by the registered manager to progress in their career by completing national qualifications.

One person told us "There's an office and I do feel free to walk-in and ask for things." People had residents' meetings and discussed a variety of topics. We saw a meeting was advertised for the day following our inspection.

All relatives told us the registered manager and the owner were approachable. Relatives said of the registered manager "I would feel comfortable approaching her if I needed to" and "She is very good, excellent, always very friendly and caring." Another relative told us that they would also be happy to speak with the staff, describing them as well informed, in particular their relative's keyworker (a staff member who works closely with a person and their family).

There were visiting times displayed at the entrance and one person told us they were surprised to see us visiting in the morning as they thought we would not be allowed to visit at that time. We discussed with relatives if there were restrictions about visiting their family members. One relative said they did visit at the times displayed however felt they could probably visit at other times if they needed to. Other relatives told us they visited at a variety of times regardless of the notice and were always welcomed. We raised this with the owner and registered manager who explained visitors were welcome at any time. The notice had been displayed to stop late calls that might disturb people's sleep. The registered manager said they would take the notice down as it might give a false impression that people's visitors were not welcome at all times.

The service was audited by both the owner and the registered manager. The owner visited the service throughout the weekend and walked through the service and garden area and undertook an environment

check, noting and repairing any reported or found repairs such a sticking doors or missing light bulbs. The registered manager audited the medicines with the senior staff member on a weekly basis counting all tablets and checking all medicines records. The medicines received from the pharmacist were also checked to ensure they were correct. We saw a list made by the registered manager following audit where medicines were not correct from the pharmacist and action was being taken to address this. The pharmacist undertook a yearly audit at the service. In addition the registered manager audited training documents, care plans, risk assessments, daily care records and 'significant events' forms monthly to ensure everything was written up appropriately in a timely manner and any concerns acted on.

The service undertook a survey of people and relatives. Surveys were sent out every three months for people living in the service. Health professionals were also asked to complete surveys. We saw that the service addressed negative responses, for example one person wrote they liked to read and write and needed a lamp. This was immediately put in place. Responses were shared with people living in the service.

The service is a private home and not part of a larger organisation. As such the registered manager explained they welcomed support from the local commissioning body and had received a visit from them. They also worked with the community health services such as the GP and district nurses.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care REG 9(1)(3)(a)(b)(c) Care was not being offered in a person centred manner that allowed for people to make informed decisions.

The enforcement action we took:

None

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent REG 11(1) People who lacked mental capacity to consent to the arrangements for their care or treatment had not received mental capacity assessments and subsequent best interest meetings. People who lacked mental capacity to consent to the arrangements for their care or treatment had not been assessed under the Deprivation of Liberty Safeguards.

The enforcement action we took:

None