HC-One Limited

Ashbourne Lodge Care Centre

Inspection report

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Date of inspection visit:
23 August 2017
30 August 2017

Date of publication:
04 October 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 and 30 August 2017 and was unannounced. This meant the staff and provider did not know we would be visiting.

Ashbourne Lodge Care Centre provides care and accommodation for up to 40 people, some of whom have a dementia type condition. On the day of our inspection there were 38 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in June 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Ashbourne Lodge Care Centre.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the manager. People who used the service, family members and staff were regularly consulted about the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Ashbourne Lodge Care Centre

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 23 and 30 August 2017 and was unannounced. One adult social care inspector and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch, who is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with six people who used the service and six family members. We also spoke with the manager and four members of staff.

We looked at the care records of three people who used the service and observed how people were being

cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

We carried out observations of staff and their interactions with people who used the service. 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 may not be able to talk with us.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe at Ashbourne Lodge Care Centre. People and their family members told us, "Of course I feel safe here, I always get help straight away", "I definitely feel safe and all the staff are very nice to me" and "[Name] feels safe with the staff who look after her."

There were sufficient numbers of staff on duty to keep people safe. We discussed staffing levels with the manager and looked at staff rotas. Staffing levels varied depending on the needs of the people who used the service. Dependency tools were used to measure people's individual dependency levels and these were used to calculate staffing levels. Staff, people who used the service and family members did not raise any concerns regarding staffing levels at the home.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

The home was clean and there were no unpleasant odours present. People who used the service told us, "I give cleanliness 10 out of 10" and "Spotlessly clean."

The provider had a 'Falls prevention and management policy' and staff, including the manager, were part of an in-house 'Falls team.' The manager told us the in-house falls team provided advice and guidance to other staff on the management and recording of falls.

Accidents and incidents were appropriately recorded and risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Equipment was in place to meet people's needs including hoists, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly.
People who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant appropriate

information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation, such as a fire or flood.

We saw a copy of the provider's safeguarding policy and procedure was displayed on the home's notice board. We found the manager understood safeguarding procedures and had followed them, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people.

We found appropriate arrangements were in place for the safe administration and storage of medicines. Staff were suitably trained and medication competency checks were carried out regularly.

People's medicines care plans described the person's understanding in relation to medicines, how medicines were taken, whether the person had any high risk or covert medicine administration needs, and any other concerns or considerations to be taken into account. Covert medicine administration is when staff administer medicine without the person's knowledge or consent. No covert medicines were in use at the time of our inspection.

Medicine administration records (MAR) we saw were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Records included an up to date photograph of the person, details of their GP, whether they had any allergies, and their preference regarding how their medicines were administered.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People and family members told us, "The staff have the right skills and they seem very caring", "The staff put themselves out to help you", "The staff are hugely skilled" and "The staff absolutely have the skills and training to look after me."

Staff were supported in their role and received regular supervisions and an annual appraisal. Supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff received individual supervisions but group supervisions also took place if the manager had something specific to discuss with a larger number of staff.

The majority of staff mandatory training was up to date and where training was due, we found this had been planned. Mandatory training is training that the provider deems necessary to support people safely and included emergency procedures, fire safety, food safety, health and safety, infection control, manual handling, safeguarding, safe people handling, and equality and diversity. Staff also completed role specific training, for example, dementia awareness, mental capacity and dignity in care. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

People had 'Diet notification' records that included information on people's dietary needs, likes and dislikes, allergies, and whether any assistance was required with eating and drinking. We saw one person required supervision at meal times and some assistance with cutting their food up due to risk of choking. The person was not on a specific diet, however, had been referred to the speech and language therapist (SALT) for a swallowing assessment. Their recommendations were included in the person's eating and drinking care plan. A Malnutrition Universal Screening Tool (MUST) was in place and reviewed monthly. MUST is a screening tool used to identify if adults are malnourished or at risk of malnutrition. The person also had an up to date choking risk assessment that was reviewed monthly.

We observed lunch on the first day of our inspection and saw people were seated in the dining room shortly before lunch was served. Some people chose to eat in their own bedrooms and food was served to them on trays. We observed staff supporting people who required assistance and regularly checking if people were happy and satisfied with their meal. People were offered a choice of food and drink and regularly asked if they wanted anything else. Staff wore appropriate protective clothing, and served lunch and assisted people in a calm and friendly manner. People and family members told us the food was good and there was always a choice.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available.

Communication plans were in place for people and recorded their communication preferences, whether the person had any issues with speech, language, vision or hearing, any capacity or consent issues, and communication strategies to facilitate improved care and support. Relatives' communication records were stored in people's care files and documented any conversations with family members.

Some of the people had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service and family members had been involved in the decision making process.

People who used the service had 'My care passports' in place, had access to healthcare services and received ongoing healthcare support. The aim of the passport is to provide hospital and care staff with important information about the person and their health if they are admitted to hospital or another care setting. Care records contained evidence of visits to and from external specialists including GPs, social workers, community nursing teams, dietitians and SALT. A family member told us, "[Name] has all the health care provision she needs."

Some of the people who used the service were living with dementia. We looked at the design of the dementia unit and saw communal bathroom and toilet doors were painted a different colour and were appropriately signed, and walls were decorated to provide people with visual stimulation. For example, there were two themed corridors to reflect a local street with different shops, and a beach. Tactile objects were attached to walls and included kitchen equipment, games, locks and switches, arts and crafts, and toy musical instruments.

Carpets were clean, not patterned and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. Corridors were clear from obstructions and well lit, which helped to aid people's orientation around the home. This meant the service incorporated environmental aspects that were dementia friendly.

Good

Is the service caring?

Our findings

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way and we saw and heard how people had a good rapport with staff. Family members told us, "The staff here are kind and they can have a joke with [family member]" and "The care is excellent."

People had 'Respecting' care plans in place. These described how staff were to respect the choices, rights and independence in all aspects of people's day to day living. For example, staff were to offer choices with regard to religious services, whether people preferred male or female care staff, the support people required with hygiene needs, and daily choices regarding food and drink, clothing and bed times.

The service had a 'Dignity, choice and respect' notice board. Information and guidance was posted on the board as a reminder for staff. The manager told us the home did not have 'Dignity champions' as all staff had been trained in dignity and it was the responsibility of all staff to be aware of respecting people's dignity in their role.

We saw staff knocked on bedroom doors and asked permission before entering people's rooms. People's care records described how staff were to promote dignity and respect people's privacy. For example, "Staff to always respect [name]'s privacy, to knock on her door before entering her room and to close doors when assisting [name] with personal hygiene needs" and "Staff to demonstrate empathy at all times."

All the family members we spoke with told us staff respected their relatives' privacy and dignity. A family member provided an example of how staff had sat down with their relative and talked about their preferences, for example, whether they wanted bubble bath in their bath water. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Care records described how people were supported to be independent. For example, "Staff to encourage [name] to keep her independence", "[Name] is able to wash his hands and face. He will need assistance with washing and drying the rest of his body" and "[Name] will need gentle prompting to change his clothes. People told us their independence was promoted and a family member told us how staff encouraged their relative to use their walking frame so they could mobilise independently around the home. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

People could have visitors whenever they wished. The manager told us how family members who lived in other parts of the country or in a different country could contact their relatives by telephone or Skype.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We saw information regarding

advocacy services was made available to people and visitors.

End of life care plans were in place, which described people's preferences for their end of life care. For example, their preferred place for end of life care, who they wanted to be contacted, what was important to the person, and what level of intervention/treatment the person wanted for their end of life care. This meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Good

Is the service responsive?

Our findings

People's needs were assessed before and after they started using the service in order to develop care plans. We found care records were regularly reviewed and evaluated.

Each person's care record included a 'Resident profile', which recorded what was important to the person, what they liked to do and what their personal care needs were. For example, one person enjoyed listening to CDs, reading, poetry and their own company. Their personal care needs included assistance to wash and look respectable, dressing and undressing, and support via verbal encouragement and prompts.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Care plans were in place and included personal care, mobility, eating and drinking, falls, safe environment, medicines, activity and social care, sleeping and rest, skin integrity, bladder and bowel, friendship, financial, respect, behaviour that challenges, DoLS/mental capacity, and end of life wishes.

Assessment tools and risk assessments were in place for people who needed them. These included Waterlow risk assessment (pressure damage risk assessment tool), falls risk assessment, bladder and bowel assessment, and oral health assessment. For example, the Waterlow risk assessment for one person identified them to be at very high risk of pressure damage due to immobility. The person's skin integrity care plan described how the person's skin should be checked daily and creams to be applied when needed. No concerns with the person's skin integrity were raised at the person's most recent review.

Another person had a wound care plan in place for a pressure ulcer. The care plan described the actions to be taken by staff to manage the wound and included guidance provided by the community nurse. The person's Waterlow risk assessment identified them as being at very high risk. The person had specialist equipment in place, including an air flow mattress, cushion and profiling bed. A body diagram recorded the site of the wound. The care plan had been evaluated monthly and the latest evaluation showed the wound was clear.

Daily records were maintained for each person who used the service. Records we saw were up to date and included information on sleep patterns, diet, activities and any health concerns. Body mapping records were also in place for people that recorded any skin damage, bruises or injuries.

We found the provider protected people from social isolation. The activities boards described upcoming activities at the home including a Summer fete, visiting musicians and singers, and pet therapy. People had 'Activity and social care' plans in place that described their preferences in relation to social care and activities, previous hobbies and activities enjoyed, current hobbies and activities, and any health considerations. People had completed activity questionnaires to say when they liked to participate in activities, whether they liked to go out, and what type of activity they liked. Individual monthly activity records described people's involvement in activities. For example, one person with limited mobility enjoyed joining in a "sing a long" and enjoyed watching others dancing and singing. In a previous month they had

enjoyed joining in with the Queen's birthday celebrations and listening to a visiting entertainer.

The provider had an effective complaints policy and procedure in place. The complaints procedure was displayed on the home's notice board and stated that all complaints would be acknowledged within 24 hours and responded to where possible within 14 days.

The manager maintained a log of all complaints recorded at the home. There had been three complaints recorded in the previous 12 months. For each one, we saw details were recorded of the complainant, the reason for the complaint, how the complaint was resolved and copies of correspondence, including letters sent to the complainant. All the complaints had been satisfactorily resolved. People and family members we spoke with were aware of how to make a complaint but did not have any complaints to make.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the manager about what was good about their service and any improvements they intended to make. New windows had recently been installed throughout the building and the manager told us the communal lounges and dining rooms were the next areas of the home to be upgraded.

The service had good links with the local community and links with other homes in the area, where people were invited to attend events and fairs.

The service had a positive culture that was person centred and inclusive. Staff we spoke with felt supported by the management team. Family members told us, "There have been big improvements since [manager] came", "I have total confidence in the manager", "The staff get on well together and the manager is very approachable", "The atmosphere is very good and the staff are happy in their work" and "The staff are very dedicated and the home is well managed, with a high level of professionalism."

Staff were regularly consulted and kept up to date with information about the home and the provider. Staff meetings took place monthly and staff surveys were carried out annually. The manager also held daily 'Flash meetings' each morning to review information and receive updates from senior staff.

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

The provider had a 'Quality assurance framework' in place, which included a visit to the home every two months. This included a review of any actions from the previous visit, a tour of the premises, discussions with staff and people who used the service, and an audit of documentation. The provider also carried out a full, annual audit of the home.

The manager carried out a number of regular audits within the home. These included, care records, health and safety, catering, and medicines. The manager carried out daily walkarounds of the home, which included checks on the quality of care, infection control and the dining experience. A second walkaround was carried out later each day to follow up any findings from the first walkaround.

Meetings took place monthly for people and their family members. We looked at the minutes for the most recent meeting in July 2017 and saw the agenda included the mealtime experience, cleanliness, activities, laundry, care and any other business.

Annual surveys were sent to people who used the service and family members. The most recent survey results had just been collated and had been completed by 12 family members and 20 people who used the service. The surveys asked questions on the environment, lifestyle, décor and maintenance, staffing, dignity and respect, complaints, and management and communication. The responses were positive with 100% of people and 84% of family members rating the service "excellent" or "good" overall. The survey results

included an update on action taken in response to any issues raised.

The home also used an electronic tablet to obtain feedback from people and visitors. The results of this were collated separately and were also overall positive.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.