Leonard Cheshire Disability

Ashwood - Care Home Learning Disabilities

Inspection report

Ashwood Cheshire Home
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 8 January 2018 and was unannounced.

Ashwood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashwood is a large detached Victorian house that provides care for up to eight people with a learning disability and other complex needs. It is situated near the town centre and shops, a local park and the beach. At the time of our inspection, there were eight people living at the home, some of whom had lived at Ashwood in excess of 20 years. All bedrooms are single occupancy, apart from one room, which is shared. All rooms are equipped with wash basins. There is a bathroom on the ground and first floor. The property is surrounded by gardens which are accessible to people.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. People living at the home were supported to maintain jobs and educational courses and had choice about what they did each day.

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.

Infection control was risk assessed and mitigations were put in place to protect people from the risk of infection.

Fire evacuation procedures were not completely embedded so that staff were aware of what they should do in an emergency. However there were appropriate checks of the environment and fire equipment to ensure that people would be safe in the event of an emergency.

People were supported to take their medicines as prescribed.

The service made changes as a result of incidents or accidents that had occurred to reduce the risk of them happening again.

We found one example where the provider had not considered a best interest decision for service users in line with the Mental Capacity Act 2005. We made a recommendation to the provider about reviewing their practice and documentation in this area.

There were robust processes in place for recruiting staff.

Staff training needed to be updated to meet changes the organisation had made to the training they expected employees to complete.

People were supported to attend healthcare appointments and maintain a healthy lifestyle.

People were happy living at the home and got on well with staff. People chose how they spent their time and were able to move freely around the home. People were able to maintain relationships with families and friends.

People were supported to maintain work and volunteer placements in the community. They were able to maintain their interests at home such as gardening.
People were provided with information to support them to complain if they wanted to.

Staff were supported to give their opinion about the service and make suggestions for improvements.

Audits and quality assurance checks were in place to identify where the service could improve and were monitored by the registered manager and provider. Action plans were developed and updated if any shortfalls in quality were identified and action plans put in place to address areas for improvement.

People were supported to give the provider feedback about how they could make the service better.

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.

Risk assessments were carried out to ensure that there were procedures in place to reduce the risk of infection.

Staff were not fully aware of fire evacuation procedures however there were individual evacuation plans in place which staff knew how to access.

Medicines were managed safely.

There were enough staff to support people.

When incidents or accidents occurred, lessons were learned and changes were made to improve the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was not acting in accordance with the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS).

There were robust processes in place for recruiting staff.

Staff training needed to be refreshed in line with changes the organisation had made to the training they expected employees to complete. This updated training was planned.

People were supported to access healthcare services and maintain a healthy lifestyle.

Is the service caring?

Good

The service was caring.

People expressed that they were happy at the home and got on well with staff.

People were able to do what they wanted to and choose how they spent their time.

People were able to maintain strong links with the community.

Is the service responsive?

Good

The service was responsive.

People were supported to maintain work and volunteer placements in the community.

People's care incorporated their likes and dislikes.

People were provided with information to support them to complain if they wanted to.

Is the service well-led?

Good

The service was well led.

Staff said that they were supported by the registered manager and deputy manager and were able to have an input into people's care.

The provider carried out audits and quality assurance checks and put action plans in place to address any shortfalls in quality.

People were supported to have an input into how the service was run.

Ashwood - Care Home Learning Disabilities

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 checked 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 8 January 2018 and was unannounced. The inspection was carried out by an 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.

As part of our planning for this inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also considered statutory notifications and previous inspection reports.

We looked at two people's care records which included risk assessments and other associated records, four staff files, records relating to the management of the service and policies and procedures.

We spoke to three people who use the service, four care staff, the deputy manager and the registered manager. We spoke with the local commissioning team for their feedback about the service. We also made observations of the environment and staff interacting with people.

Ashwood—Care Home Learning Disabilities was last inspected in August 2015 where it was rated 'Good' in all domains and 'Good' overall.

Good

Is the service safe?

Our findings

One person said that they felt safe at the home and other people indicated that they were comfortable at the service and with staff.

There were infection control procedures in place at the home. The laundry was only accessible through the kitchen. However, there was a risk assessment in place and a process had been implemented so that soiled laundry was only taken through the kitchen in enclosed laundry bags when there was no food being prepared in the kitchen. This had been identified as part of a quality audit and infection control audit. The registered manager said that they were currently looking into options of relocating the laundry or adapting the building for better access.

A member of staff provided support with cleaning the home two days per week and people were encouraged to participate in cleaning to maintain their independence. Personal protective equipment was available throughout the home.

An infection control audit was carried out in December 2017, which identified that there were some areas for improvement such as a need for putting cleaning schedules in place. The deputy manager was currently working through the actions and was being overseen by the registered manager.

Risks to people's health were assessed in their care records such as if they displayed behaviour that challenged or had epilepsy. There was guidance for staff to follow to manage the risks such as how to reassure people and prevent an incident. Staff said "We do risk assessments to make sure that all residents and staff are safe". There were individual risk assessments to support people's independence such as how they could travel by bus to their place of work by themselves which included information about which bus the person would get and how staff were made aware that the person had reached their destination safely.

Staff said they were not fully aware of fire evacuation procedures and were unsure about where they would assemble in the event of a fire. The registered manager said that this would be addressed immediately and staff would be reminded of the fire evacuation procedures. Fire drills had been carried out within the last six months although not all staff were involved. Staff said that people who used the service had not been involved and there were some people who were able to understand fire evacuation procedures. However, people had personal emergency evacuation plans in place which had guidance on how people needed to be assisted in the event of an evacuation and staff said they knew how to access these. There were also signs which showed where fire exits were and emergency lighting in place.

A fire risk assessment had been carried out in February 2017. Some of the actions included repositioning the fire exit sign above the door in the hallway and fitting fire rated hinges to some of the doors. The recommendations had been followed and the actions completed.

Environmental risk assessments had been completed and all appropriate safety checks such as electrical testing had been carried out and the service kept copies of the relevant certificates such as gas safety

certificates, legionella testing and electrical wiring certificates.

There were adequate staff to meet the needs of the people who used the service. Most days there were two staff on shift in the morning and two staff in the afternoon with one staff member on duty overnight. The deputy manager oversaw the service on a day to day basis and the registered manager spent time at the service at least two days per week and additionally when needed. Permanent staff were supported by volunteers who came to spend time with people who used the service and do activities such as crafts. Most people visited a day centre during the week and staffing levels varied depending on the activities and plans that people had each day. People were able to choose whether they spent time at home or out in the community and staffing levels allowed for people to be flexible daily with how they spent their time. The service was able to utilise staff from other services run by the provider if they were unable to cover shifts with their own permanent or temporary staff.

There were appropriate procedures in place for ordering, recording and storage of medicines. All people who used the service had their medicines administered by staff. Each person had a locked cabinet in their bedrooms where medicines were stored and staff took them to their bedrooms to administer them. When people went to the day centre, they took their medicines with them with a copy of their medicines administration record which was given to them and signed for by the day centre staff. Staff at the service checked whether people had been given their medicines when they returned to the service. Some people had PRN (as required) medicines prescribed for them. There were individual protocols in place which explained when staff could administer these medicines. Medicine administration records (MAR) were completed when people were given their medicines and it was recorded if people did not have their medicines and the reason why.

There were satisfactory processes in place to ensure that staff were recruited safely. Records were kept of the application and interview processes and the provider had explored any gaps in people's employment history. The registered manager requested references from previous employers and carried out disclosure and barring service (DBS) checks prior to staff beginning work at the service.

People were protected from abuse and mistreatment. The staff we spoke with had a good understanding of their responsibilities in helping to keep people safe. Staff told us they would have no hesitation raising concerns with the registered manager or provider. Staff had access to the provider's safeguarding policy and had received training in how to safeguard people from abuse and whistleblowing. The service had a copy of the local authority safeguarding policy, protocol and procedure. This policy provides guidance to staff and to provider and managers about their responsibilities for reporting abuse.

Staff recorded incidents and accidents on incident forms which were then reviewed by the registered manager. These were recorded on the provider compliance system and analysed on a monthly basis to identify whether they were isolated incidents or there were any patterns which could be identified. This included looking at the types of injuries and immediate causes. There had been an accident where a staff member had fallen on the slope outside the kitchen. The area had been reviewed and non-slip strips had been applied to the floor to prevent further falls however the registered manager was also consulting with building contractors to look at a more permanent solution.

Requires Improvement

Is the service effective?

Our findings

People told us they were supported with eating healthy meals and showed us how they accessed fruit and snacks when they were hungry. We observed people being asked to make choices about what they did and what they ate throughout the inspection.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

There were currently no Deprivation of Liberty Safeguards (DoLS) authorisations in place. However the registered manager had recently reviewed whether they should have made applications for people. He had liaised with the local authority to carry out capacity assessments and make the applications if necessary. The registered manager thought that some people would need an application made as not everyone was able to make decisions about how they needed to be supported by staff and the local authority was supporting this the following week.

Staff were able to talk about the Mental Capacity Act and how they supported people to make decisions day to day such as by asking what they would like to wear and what they would like to eat. However staff were not always aware of when consent or the process for determining if something was in someone's best interests if they did not have the capacity to consent was required. For example, two people at the service shared a room. They had been at the service for a long time and had always shared a room. However, one of the people had a medical condition which required staff to put measures in place to monitor them overnight. Staff had not obtained consent from the people to confirm that they were happy to share a room and people had not consented to the measures put in place for the night time monitoring. The mental capacity of the people who shared a room had also not been assessed to ensure that they had the capacity to make the decision regarding sharing a room or having a listening device in their room. Staff said that as this had been this way for a long time, they did not think that they needed to review the arrangements to ensure they were the least restrictive or gain consent from the people.

We recommend that the provider reviews the arrangements for assessing capacity and gaining consent when making decisions about people's care and refreshes staff knowledge to ensure they are meeting the requirements of the Mental Capacity Act (2005).

Staff were given an induction when they started at the service and staff were supported to work towards the care certificate. Staff said that they were given the opportunity to shadow other staff and spend time getting to know people before they worked on their own.

There had been a change to the way that training was delivered which meant that some staff training had lapsed and staff had not refreshed their skills. Under the new system of monitoring training, only six out of 14 staff had completed manual handling theory training and seven out of 13 staff had completed manual handling practical training. However all staff had received training in medication and infection control. There were plans in place to ensure that staff were supported to complete the training by the registered manager however they were waiting for the broadband to be updated in order to support the online training packages to be available. This was due to happen in the week following the inspection. New staff were supported to complete the care certificate and other staff who had been at the service longer had been supported to achieve qualifications such as National Vocational Qualification's (NVQs).

Staff had not always received regular formal supervision or appraisals with a manager or supervisor to discuss their performance and the service. The registered manager had put a schedule in place to ensure that staff received supervision within the next month and appraisals were scheduled throughout the year. It had been identified that the deputy manager was not always able to carry out all of the supervisions himself, so they had now been allocated to both the deputy manager and the registered manager to complete. At each supervision, the date of the next supervision was arranged so that staff were able to be involved in arranging a suitable date. The policy required staff to attend supervisions at least every three months and the registered manager said that they would arrange them more frequently if they felt they needed to. The registered manager said that he felt that supervision had occurred in line with the recommended guidelines however it had not been documented. Staff said that they had had some supervisions, however if they needed to speak to the deputy manager or registered manager they felt able to and they were also able to raise concerns during staff meetings.

Although people and their families were included when care plans were developed, the registered manager told us that they were looking at how people could have more of an input when they updated the care plans. Although some people had been part of the reviews of their care, some people had chosen not to be. Minutes of staff minutes showed that staff had discussed how they could involve people and their families more in care plan reviews going forward. The local commissioning team told us that they were invited to participate in reviews of people's care.

People were supported to maintain a balanced diet and fresh fruit was available for people to help themselves to throughout the day. Staff said "Meals are planned on a weekly basis, we have a book with meals that the residents can look at to choose from". We observed meals being prepared with vegetable accompaniments. Some people were being supported to become healthier by working towards eating a more balanced diet. In one person's care plan it said that they were now using sweetener in place of sugar. There was additional guidance from healthcare professionals about how staff could support the person to make healthy changes. When we spoke to staff they were aware of how to support people to make healthier choices such as offering low fat desserts and fruit for snacks. Staff told us "We encourage the residents to get involved as much as possible and will let them make their own packed lunches". We saw people helping to prepare dinner with staff.

People were supported to maintain their health and wellbeing and we saw that some people had recently had learning disability health checks to identify how they could improve their physical health. This included putting goals in place such as losing weight or eating healthier.

There were health plans in people's care files for specific health needs such as epilepsy. In one person's care plan there were detailed descriptions of the person's seizures and how staff should support them. Staff were aware of what guidance was in place for monitoring the person and when they should escalate concerns. Staff had received training in epilepsy to aid their understanding and ensure they felt confident supporting the person.

Staff worked with other healthcare professionals such as mental health teams and speech and language therapists to ensure that people's needs were assessed and care was delivered in line with recommended guidance. People's care files showed that they attended appointments and check ups and any guidance given was included in their care plans. People had also been supported to have flu vaccinations to reduce the risk of catching flu and were visited by a chiropodist. The local commissioning team said that they were kept informed if staff were concerned about anyone's health.

People had regular reviews of their needs with specialist healthcare professionals such as learning disability teams and epilepsy specialist nurses and guidance was reflected in people's care plans. Staff told us that they supported people to attend appointments and invited professionals to see people at the home if they felt it would be more appropriate for the person.

The premises were in need of some updating and refurbishment however there was an ongoing plan to manage this. The provider was awaiting some additional funding before they could pursue some of the plans that they had arranged.

People's needs and preferences were taken into consideration with the design of the environment. One person had expressed that they liked gardening, so staff had built raised beds in the garden for the person to be able to plant vegetables such as potatoes. A new bath had also recently been installed into the service which was suitable for people with mobility difficulties to be able to use it as there had previously not been a bath at the service.

Good

Is the service caring?

Our findings

People showed us around the home. There was adequate communal space both indoors and outdoors and people were able to move about the home freely. People showed us their bedrooms and each person had their rooms decorated in the style that they wanted.

People were happy and staff spoke to people kindly. People were laughing with staff and talking about things that they enjoyed. Not everyone could communicate verbally however we saw staff communicating with people in ways that they were able to understand. Care plans contained detailed information about how people could communicate, for example, in one care plan it noted that although a person was able to communicate verbally, staff should allow the person to think and ask them if they understood.

We observed a person spending time with a volunteer doing crafts. The person was engaged in what they were doing and indicated that they liked doing crafts and enjoyed spending time with the volunteer. There were examples of other craft projects that the person had completed around the home.

Staff spoke knowledgeably about people and told us about their personal histories and their likes and dislikes. We saw that these were reflected in people's care plans. Staff said that they felt they had time to spend with people and were able to be led by what people wanted to do. One staff member said "I don't feel rushed. We can be flexible with what we do each day. If someone fancies going out for lunch we will take them".

We observed people making decisions such as what they wanted to watch on television and what they wanted to eat for a snack. Staff said that people weren't always involved in choosing what was on the menu however if they didn't want something, they were able to choose something else. One person had decided that they would like to go to a local café at lunchtime so a staff member supported them to go out for lunch.

People's privacy and dignity was respected. People's rooms were left closed when people were not home and staff knocked on people's doors before entering. People were asked if they would like a lock on the door however only one person had wanted one.

People were able to have visitors whenever they wanted and people's families were invited to attend care reviews. People were supported to access day centres and clubs where they could form friendships with other people outside the home. Some people liked to go out with their family and friends and the service facilitated this. Staff said "We encourage people to keep in contact with family. Family can come and visit. We do birthday and Christmas celebrations to which family members can come".

People's information was kept securely in a locked office and was only accessible by staff. If people wanted to keep information in their bedrooms, they were able to have locks on their doors or lockable storage such as drawers. Staff asked people if they minded whether they shared their care plans with us before they gave them to us.

Good

Is the service responsive?

Our findings

We observed people choosing what they wanted to do in the home such as watching television and helping to make dinner. People indicated that they were able to choose what they wanted to do and showed us how their preferences were reflected around the home such as having individually decorated rooms.

Staff said that people were mainly left to choose what they wanted to do each day for themselves. Volunteers came in some days to spend time with people and people visited day centres during the week. People who did not visit the day centre were taken out for walks or for lunch at local cafes. Staff said "We go out on day trips with the minibus or often just for walks in the park with the residents to make sure that they are getting some exercise and fresh air". One person was supported to maintain a job at a garden centre and also do some voluntary work.

People were supported to make choices which reflected their personal preferences such as accessing other services and educational classes. People were able to choose what they did with their time and if they attended any day centres or activities.

People had told staff that "Family, soft toys and a calm and peaceful environment" were important to them and this was reflected in people's care plans. Staff were able to talk about what people liked and people showed us their favourite things around the home such as books about boats and shoes.

People's care plans contained goals they wanted to achieve such as to enrol in voluntary work to allow them to build confidence and relationships outside of the home. There was information in people's care files about their hobbies and how they were supported to enjoy them such as going on boat trips. People showed us photos of them doing things that they liked.

Each person's care files only contained risk assessments and care plans that were relevant to them. For example, if someone had a medical condition such as epilepsy, there were specific risk assessments in place to ensure they were safe. Staff told us that they talked to people about their care plans and asked them to talk about what they wanted. Staff said that relatives were invited to review them however they were not always able to attend. Care plans were written in a way that people could understand and included pictures and larger print if people needed them.

Staff were fully aware that any health problems would need medical attention either by attending the doctors surgery or calling an on call doctor. People's family would also be contacted to ensure that they were kept informed. Staff said "If residents are unwell we would call a doctor or the out of hours service to seek medical advice. Any concerns are written in the communication book' Staff checked the communication book at the start of each shift to ensure they were up to date on any changes to people's health.

Staff were aware of how to manage complaints and said that most complaints were informal and not documented. The service had not received any formal complaints in the last 12 months. However, there

were systems in place for reporting and analysing by the provider if any were received using their compliance system which all services reported into on a monthly basis. The registered manager and staff were able to describe how they would support people to complain if they needed to.

People were given a document which explained how they could complain if they needed to which was produced in an easy read format. The company complaints procedure explained how people could send their complaints to the Local Government Ombudsmen if they were unsatisfied with the outcome of their complaints response.

There was no one at the service who was considered to be at the end of their life. People had end of life care plans in place however there was little information included about people's preferences when the end of their life came. Staff said that people didn't like to talk about this however they did ask people when they did care reviews.

Good

Is the service well-led?

Our findings

People indicated that they liked the registered manager and were eager to interact with him. People wanted to show him what they had done during the day. We observed that staff knew the registered manager well and spoke openly with them about the service. Staff said "I feel confident that if I had a concern I would report it to the manager and it would be dealt with immediately".

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.

Since the last inspection, the registered manager had changed. The day to day management of the service was done by the deputy manager and the registered manager provided support two to three days per week and was available if needed on the other days as they were responsible for other services.

Staff said that they liked working at the home and most had been there for a long time so knew the provider and the service well. Staff said "We feel like a big family here and respect that this is someone's home that we're working in".

The registered manager and deputy manager carried out 'out of hours' audits overnight to check the quality of the service during the night. An audit in July 2017 had identified that a person needed changes to their night care plan. We saw that this had been updated.

There was a system in place for carrying out audits on a monthly basis which were entered onto a compliance system so that actions could be monitored by the registered manager as well as the provider. Audits included a review of incidents and accidents, infection control and medication.

There was an action plan put in place following a senior manager audit which had highlighted numerous areas for improvement. The audit had covered all areas of the home and looked at health and safety, staffing, care planning and delivery and the Mental Capacity Act. Actions identified included updating health and safety risk assessments, reviewing care plan documentation and carrying out some maintenance around the home. Some of the actions had already been completed such as reviewing supervision arrangements, and deadlines had been set for some of the actions such as reviewing all care files to allow them to be thoroughly reviewed however it was too soon for the improvements to be embedded and sustained. Further improvements were needed which take longer to implement such as identifying how the laundry could be accessed without needing to take soiled laundry through the kitchen.

Staff meetings were held every three months and there was a schedule in place for meetings over the next year. Staff were able to have an input into meetings and make suggestions such as requesting a carpet cleaner to enable staff to clean the carpets. Meetings also enabled staff to talk about people's needs and make plans such as holidays and Christmas parties as well as discuss changes to the service.

People were asked for their views about the service. An external company came and asked for people's opinions on their activity choices and identified that people would like to go out more. The service had purchased a minibus to take people out on day trips in response to their feedback that they would like to go out more.

People were sent a questionnaire in a format which was suitable for them to understand such as pictorial so that they were able to feedback their views. People had expressed that they were happy and no concerns had been indicated.

The registered manager and deputy manager were working with the local authority to ensure that people's capacity to consent to their care and treatment was appropriately assessed and any applications required under the Mental Capacity Act 2005 were made. The local commissioning team were invited to care reviews to ensure that people were receiving appropriate care that met their needs. The service worked with other healthcare providers such as mental health teams and learning disability teams to ensure that assessments of people's mental and physical health were carried out and any advice and guidance was carried forward into people's care plans.

The registered manager was aware of his responsibilities as a registered manager and spoke about how he met the requirements of duty of candour. The commission was notified of any incidents and changes to the service required. The service was properly displaying the rating from the last inspection both at the service and on the provider website.