Restful Homes (Sutton Coldfield) LTD

Asprey Court Care Home

Inspection report

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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

The inspection took place on the 22 May 2018 and was unannounced. This was the first inspection of the service since registering with us in August 2017.

Asprey Court 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.

Asprey Court accommodates 86 people in one adapted building. At the time of the inspection, there were 36 people living at the home. The home was separated into four units although only three were currently used. One unit accommodated people with complex nursing needs relating to their dementia, the other two unit provided nursing care for older people with Dementia.

A manager was registered with us, however we had been made aware prior to the inspection that the registered manager had left. A new manager was in post and in the process of registering with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who knew how to report concerns and manage risks to keep them safe. Staff were safely recruited and there were enough staff available to support people. Medication was given in a safe way, and there were safe systems in place to prevent the spread of infection.

The provider utilised innovative technology and design to ensure that the décor of the service supported people's needs; reducing the risks posed to people and promoting their independence. The design, layout and decoration of the service had considered how to meet people's needs without the need for further clinical equipment; meaning that people could be supported within a 'homely' environment.

People received support by appropriately trained staff. Training provided to staff was individual to the needs of the people they supported. People were happy with the meals they were provided with and had access to healthcare services where required. People had their rights upheld in line with the Mental Capacity Act.

People were supported by staff who were kind and caring. People were treated with dignity and involved in their care. Where able, people were supported to maintain their independence. Advocacy services were available if needed.

There were systems in place to assess and review people's needs to ensure their care needs were met. There were activities available for people that met their interests. Although complaints were acted upon, further work was required around the recording of complaints.

People spoke positively about the new manager and the support provided by her. There were systems in place to monitor the quality of the service, although further work was required around the level of detail held in records. People had been asked for their feedback on their experience of the service and the provider had a clear vision for the future 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?

Good

The service was safe.

People were supported by staff who knew how to manage risks to ensure their safety.

There were sufficient amounts of staff to support people. Staff were recruited safely.

Medications were given safely and there were effective infection prevention systems in place.

Is the service effective?

Good

The service was effective.

Innovative technologies and designs were implemented to meet the needs of the people living at the home.

Staff received appropriate training and supervision.

People had their rights upheld in line with the Mental Capacity Act and had access to healthcare services where needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind, caring and promoted their dignity.

People were involved in their care and encouraged to maintain their independence where possible.

People had access to advocacy services where needed.

Is the service responsive?

Good

The service was responsive.

People's care needs were reviewed and records updated as required. People were supported by staff who knew them well.

Activities were available that met people's individual interests.

Complaints made were investigated but records kept of complaints required further improvements.

Is the service well-led?

Good

The service was well led.

People and staff spoke positively about the leadership at the service.

There were systems in place to monitor the quality of the service, although further improvements were required in the level of detail kept in records.

People were given opportunity to feedback on their experience of the service.

Asprey Court 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.

The inspection was prompted in part by concerns raised to us by visiting health professionals regarding whether the provider was able to meet the needs of people with complex care needs. The concerns were discussed with the provider as part of this inspection.

This inspection took place on 22 May 2018 and was unannounced. The inspection was completed by two inspectors, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has experience of using or caring for a person who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. Due to technical problems, the provider was not able to complete a 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 contacted the local authority to gather their feedback about the service.

We spoke with seven people living at the service, four relatives and a visiting health professional. As some people were unable to tell us their views of the service we completed a Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with one member of care staff, a nurse, two senior members of care staff, the quality and compliance manager, the home manager and the provider.

We looked at care records for four people, two staff recruitment records and the staff training matrix. We then looked at records held in relation to accidents, incidents, complaints and systems in place to monitor the quality of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us, "I do feel safe here. I am not worried about anything". Another person told us that due to reassurances given to them by the provider about their safety at the home they felt they were able to "relax and enjoy life again".

Staff we spoke with had received training in how to safeguard people from abuse and could explain the actions they would take if they thought someone was at risk of harm. One member of staff told us, "I would approach the person and make sure they were safe and inform my unit manager". We found that where concerns were raised these had been referred to the local authority safeguarding team as required.

We received concerns prior to the inspection that risks to people who had complex care needs were not well managed. We looked at this during the inspection and found that identified risks to people were managed well and this meant people were safe. For example, we found some people displayed behaviours that may challenge and that this could result in staff needing to restrain the person. We found that all staff had received training in how to do this safely and could confidently explain the procedure involved with this. Records were maintained where restraint was used and the manager analysed these records to look for trends in people's behaviours that would potentially reduce the need for restraint in future. Restraint was used in accordance with the Mental Capacity Act and Deprivation of Liberty Safeguards. Where people required support with their mobility, this was provided in a safe way. We saw a member of staff support a person to stand. The staff member encouraged the person and reminded them of the safest way to stand and supported them in this action. One other person was at risk of falling from their bed. Staff we spoke with were clear on how this risk should be managed to ensure the person's safety. We identified that although risk assessments were in place, further detail in these would ensure that any temporary staff would be better prepared to support people with their identified risks. However, all of the permanent staff spoken with displayed a good knowledge of people's risks and how to manage these and the manager provided assurances that further detail that reflected staff's knowledge would be included in risk assessments in future.

There were effective recruitment systems in place that reduced the risk of unsuitable people being employed. We found that prior to commencing employment, staff had been required to provide references and complete a check with the Disclosure and Barring Service (DBS). The DBS would show if a staff member had a criminal record or had been barred from working with adults. We saw that where these checks had identified a potential risk, the manager had completed a risk assessment to ensure that the staff member would be safe to work with people.

People gave differing feedback when asked about staffing levels. Some people felt there were enough staff to meet their needs. One person told us, "I know if anything goes wrong, they [staff] are only a buzzer away" and a relative added, "I have never known it to be not fully staffed, I can't fault the place". However, other people felt extra staff were needed. One relative told us, "There are some lovely staff here, I just feel that they are very short staffed".

We saw that there were sufficient amounts of staff available to support people and that where people required assistance; this was provided in a timely way. We saw that the provider had commenced a recruitment programme and had recently recruited a nurse and four new care staff who were completing their induction on the day of inspection. While recruitment was ongoing, the provider had used temporary staff to ensure safe staffing levels. Staff told us the provider had been proactive in ensuring a regular group of temporary staff were used to provide consistency of carers for people. The provider also had an ongoing recruitment plan to ensure that additional staff were available as the number of people living at the home increased.

We found there to be safe infection control practices in place. Staff had received training in how to prevent the spread of infection and we observed staff using personal protective equipment [PPE] safely. The home was clean and odour free.

We had received concerns prior to the inspection that medication errors had occurred. We looked at this and found that medications were given in a safe way. We saw staff supported people to take their medication and this was done safely. The staff member informed the person that it was time for their medication and then stayed with them while they took this. We checked the systems in place for the storage of medication and found that medication was being stored safely. We found that Medication Administration Records [MAR] had been completed fully which indicated people had received their medications as required. Where people had medication on an 'as and when required' basis, there were protocols in place providing guidance for staff on when these medications should be given. This reduced the risk of medication being given in an inconsistent way. We found that some protocols for 'as and when required' medications were not in place on one floor but were given assurances that these would be put in place. Staff responsible for giving medications on this unit had an understanding of when these medications should be given and so people continued to receive their medication when needed.

The manager displayed a proactive approach to learning from when things went wrong. We found that where incidents occurred, action was taken and learning took place to prevent the likelihood of incidents reoccurring. For example, the provider told us how they had taken action to replace furniture after identifying that the current furniture was not easily cleaned and so posed an infection risk. This showed that where issues were found, the provider was proactive in taking action and learning from these.

Good

Is the service effective?

Our findings

The design and decoration of the service ensured people's needs would be met. This had been achieved through innovative technologies and design plans. The provider informed us that when they were designing the newly built home, their intention was to ensure that people's needs would be met without them feeling that they were in a 'care home.' The provider was keen to ensure that people were able to live in comfortable surroundings where their needs would be met using their existing furniture and reducing the need for equipment such as pressure cushions or bed rails; which the provider felt made homes look more clinical than homely.

The provider had custom designed all of the furniture in people's bedrooms to reduce the risk of falls without the need for equipment. For example, beds had been designed that were closer to the ground than standard beds. This would lessen the impact of any falls that may occur but would otherwise only be available on hospital style profiling beds. The provider had also had all beds made wider than the standard width of a single bed to reduce the risk of people falling as they were not positioned so close to the edge with the extra width. Bedside tables had been designed without shelving close to the ground as a falls prevention measure to reduce the risk of people needing to bend down to reach their items. All of this furniture had also been adapted to suit the needs of people with dementia or those with mental health needs, with slow closing drawers and each item being made with robust, heavy materials that would prevent people from being able to pull furniture over.

People's bedrooms were spacious and promoted and encouraged independence. The bedrooms had been fitted with audio monitoring systems that, if people agreed with their use, would alert staff to any issues as these arose and potentially reduce the number of times that staff would need to enter a person's room to check on them throughout the night. This gave people a choice on what level of night time welfare checks they would like to receive. The provider had ensured that whilst available for everyone, the audio monitoring systems would only be used by those who understood and were able to consent to their use.

Every seat within the home had been especially designed by the provider to reduce the need for pressure mats where people were at risk of developing pressure areas. The provider informed us that all chairs had been designed with built in pressure relief so where people became at risk of pressure areas, there would be no need for further equipment for people.

Although there was a team of kitchen staff to prepare meals for people, each communal lounge had a small kitchen with equipment for people to practice meal preparation and make their own meals if they chose to. This meant that those people who wished to maintain their independence and meal preparation skills had the amenities available to do so.

The needs of people with dementia had also been considered in relation to the decoration at the home. For example, the provider had custom designed the wallpaper throughout the building so that the colour contrast between the walls and the floor would be at the optimum level to support people with dementia moving around freely whilst still maintaining décor of a high quality standard. This had involved the provider

researching the benefits of colour contrasting decoration for people with Dementia and identifying the most beneficial colour contrast to support independence. They then used this information to design wallpaper that reflected the identified colour contrast. This evidenced that the provider had carefully considered the needs of people when designing the home and had provided innovative techniques to reduce any risks and promote independence within the décor of the home.

Staff told us that before they commenced work at the home, they had been required to complete an induction that involved completing training and shadowing a more experienced member of staff. Staff were overwhelmingly positive about the support they received during their induction, with one member of staff commenting that, "The induction covers everything and is very thorough. I was informed about exactly what I would be doing. The [staff members I shadowed] worked really closely with me". We saw records that evidenced the induction covered mandatory training as well as the completion of the Care Certificate. The Care Certificate is an identified set of standards that care workers are required to adhere to.

Staff told us training helped equip them with the skills they needed to support people effectively. One member of staff told us, "The training here is the best I have ever been on". We saw that where people had specific care needs, training was provided in this area. Staff told us that training was available on an 'as and when needed' basis and was tailored to people's individual care needs. A member of staff gave an example of a time that methods of restraint were not working for one person. The staff member said, "Within 24 hours, the manager had got the trainers back in to give us some bespoke advice". This evidenced that the manager had tailored the training given to be individual to people's needs and that training could be accessed at any time to reflect people's changing needs.

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.

People told us and we saw that people were asked for their consent before staff provided them with support. A member of staff told us, "I gain consent by speaking with people. For those who cannot verbally communicate, we use non-verbal cues such as nodding their head". To ensure that people's rights were upheld in line with Mental Capacity Act, the provider had recruited a psychiatric specialist to provide ongoing training and advice for staff, review any concerns around people's capacity and support relatives to understand their loved ones conditions and how the MCA is applied. This meant that staff had access to advice and support in relation to MCA on an 'as and when required' basis and that this advice could be tailored to people's individual circumstances. Our observations of staff showed they understood how people should be supported to make decisions based on their individual needs.

We saw that a number of people living at the home had DoLS authorisations in place. Records we looked at showed that these applications had been made appropriately. We saw that where best interests decisions were required, the provider had sought the views of a number of other people to assist with the decision making process. The manager told us, "We will always involve family, social workers, doctors and the service commissioners to make decisions in people's best interests". Staff we spoke with understood who had a DoLS authorisation in place for the unit they worked on.

People told us they were happy with the meals they were provided with. One person told us, "The food is lovely thank you". People were able to eat their meals at a time to suit them with one person telling us that if they were not hungry at the usual meal time, then staff would prepare their food for later in the day when they were ready to eat. The person also explained that staff met their request for snacks during the night when they had been unable to sleep. This showed that mealtimes were flexible to meet the wishes of each person. We found that there was a choice of meals available and people had a choice of drinks at the dining table. Where people did not want the food offered on the menu, we saw that alternatives were offered.

Mealtimes were a sociable experience with staff sitting with people at tables where they ate. Although at some tables the conversation was minimal, at others staff actively encouraged conversations amongst the people at the table and were seen to be laughing and joking with people as they ate. People responded positively to these interactions.

People had access to healthcare services where required. We saw that the provider; following talks with their local GP practices had arranged for twice weekly visits from a GP for people to discuss any health concerns they had in addition to accessing emergency 'on the day' appointments where required. Records we viewed showed that people had been supported to see other services including Psychiatric teams. The Provider had been proactive in working with other healthcare services. For example, the provider had implemented information packs to be shared with health professionals where needed to ensure that all agencies had the information they needed regarding people's health needs.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring to them. One person told us, "I could not wish for better carers. They are all so kind. No matter what I ask these carers to do, they do it. They are golden". Another person said, "They [staff] are very good. If I want something I just got to ask". Relatives we spoke with also felt the staff were caring. One relative told us, "[Person's name] is happy here. She is always hugging the care staff".

We saw staff had developed kind and friendly relationships with people. For example, we saw plenty of conversations between staff and people that involved joking and laughing. People were visibly relaxed in the presence of care staff and could be seen hugging them and telling them 'I love you.' Staff consistently responded positively to these interactions and encouraged people in expressing themselves in this way if they chose too.

People told us they were given choices and felt involved in their care. We saw that people were given choices about where they would like to spend their day and what activities they would like to take part in. We saw that where people had specific communication needs, staff were aware of how to communicate effectively to ensure that people continued to have choices. We spoke with one staff member who gave us an example of how they supported one person who was unable to verbally communicate. The staff member had an in depth knowledge of the person's communication preferences; including the pictorial aids and flashcards that the person did not like to use, and could demonstrate how they used this knowledge of the person to communicate with them. This meant that people's communication needs were met to ensure they were able to communicate their choices. Relatives we spoke with also told us they felt involved in their loved ones care and were kept informed of any changes. One relative told us, "It's really nice to know what happens with [person's name]".

People felt staff treated them with dignity. One person told us, "[Person's name] has got his dignity back. He has got his life back". Another person added, "We have a lot of respect for them [staff] and they have a lot of respect for us". We saw that staff ensured people's dignity. People appeared well presented and women at the service were supported to have their hair done and nails painted. We saw that people's privacy was respected and that where people were spending time in their bedrooms, staff knocked the door and waited for permission prior to entering.

The provider had implemented systems to support people to be independent. For example, ensuring that kitchen facilities were available for those who wished to prepare their own meals. Staff we spoke with told us how they supported people to complete their personal care independently. A staff member told us, "I ask if any assistance is needed. If the person says no, then I respect that and will wait nearby so that the person can do the task alone but I am close by if needed".

The manager displayed a good understanding of where advocacy services would be required and how these could be accessed. Any advocacy requirements were discussed with people as part of their initial assessment. An advocate can be used when people have difficulty making decisions and require this

support to voice their views and wishes.

Good

Is the service responsive?

Our findings

Prior to moving into the home, people's needs were assessed to ensure that their care needs could be met by the provider. These assessments considered people's physical health needs, their mental health needs and their medical history. The assessments also ensured that any protected characteristics under the Equality Act would be met and people were asked about any needs they had in relation to their religion, culture and sexuality . We were told by one person about how the manager and deputy manager had gone out of their way to support them during their initial assessment and ensured that they were involved in the decision to move to the home. The person told us how they had been unable to visit the home prior to moving in due to health issues. In response to this, and to ensure the person had the opportunity to see the home prior to agreeing to move, the managers made a video recording of the facilities at the home and took this to them to view so that they could see where they would be living. This evidenced that the provider responded to the person's individual needs to support them in their move to the home.

We found that people's care records were reviewed and updated when required. The provider had implemented an electronic system to record details about the care being delivered to people. This information was recorded via handheld devices given to staff. The devices ensured staff had access to up to date information about people's care needs and were able to update records as and when needed as they always had their handheld devices with them. Staff spoke positively about this method of care recording and one member of staff told us, "It makes it a lot easier, as you don't always have time to sit and write things down, but with the devices, you can update as you go". The provider informed us and relatives confirmed, that people and their relatives, where people agreed access to this, could have access to the system to view their care records at any time. They also spoke of their intentions to further develop this system to ensure people and their relatives could get further involved in care planning by accessing the information held within the system remotely at times to suit them; increasing the flexibility of people being able to be involved within their care planning.

People felt that staff knew them and their care needs well and this was evidenced in our conversations with staff. When discussing the people they supported, staff were able to tell us about people's life histories, their families, as well as their care needs and how they like their care to be delivered.

There was no one living at the home who had end of life care needs. However, from records we viewed we could see that people had been asked about any special wishes or religious/cultural practices they would like to have adhered to in the event of their passing. This showed that although people were not at the end of their life, the provider was keen to ensure that people's wishes would be known and met should the situation arise.

People told us they were satisfied with the activities on offer at the home. One person told us they were offered lots of different activities and events and were encouraged to join in with these. The home had its own open access bar and two cinema rooms available for people to use as they wished and we saw people accessing the cinema to watch a film during our visit. Other people were being supported to access the garden area and enjoy the sunny weather. People visibly enjoyed this activity and we heard one person

happily telling staff they had been out in the garden. People told us there were a number of events ongoing at the service and that they had recently held an afternoon tea to celebrate the Royal Wedding and had a visit to the park for a beer and an ice cream.

People told us that they felt complaints made were taken seriously and investigated. One person told us, "If there is anything I am not happy with, I talk to [managers name]. They have said to tell them if there are any problems so they can sort it out". Records we looked at showed that only one complaint had been made. We could see from this that action had been taken and that this had been resolved. However, following the inspection, we received information that indicated other complaints had been made about the service that were not available in the records that we viewed. This meant an accurate record of complaints made was not kept; although we were able to see that complaints had been looked into and that meetings had been held with the complainant to discuss. We also saw that the complaints procedure was available for people to view within the main entrance of the home, but this was not available within an accessible format. We spoke with the provider who advised us they had systems in place to provide information / signage in accessible formats such as Braille if required.

Good

Is the service well-led?

Our findings

There was a manager registered with us as required in the conditions of the provider's registration. However, we were made aware that this manager had left the service in November 2017. During the period following the registered manager's departure, a new manager had been in place and was present on the day of the inspection. The manager was in the process of submitting their application to register as the manager of the service.

People spoke positively about the new manager and the impact they had on the service. One person told us, "She [manager] is hands on and really nice". A relative added, "She is very much on the ball all the time. I have to remember that she has other people to look after as well". In addition, people also told us they enjoyed friendly relationships with the provider and that they received regular visits from the directors of the business. We saw the two director's visit on the day of the inspection and observed they appeared to know people well and had developed a good rapport with people.

Staff also felt supported by the provider and the manager. One member of staff told us, "I feel very supported by everyone. The support I get from [manager's name] is immense. She is always on the floor, speaking to everyone, helping out where needed". Staff felt confident in raising concerns with the provider and were confident she would act on any issues that arose. Staff we spoke with understood the whistleblowing procedure and knew how to whistle blow if needed. We saw that where concerns were raised, the manager was aware of how to report these and knew what they was required to submit to CQC [Care Quality Commission] in terms of notifications.

We saw that systems were in place to monitor the quality of the service. For example, auditing systems were in place that covered looking at care records, medication, infection control and people's dining experience. We saw that where areas for improvement were identified, an action plan was implemented to address this. Whilst we saw some actions were complete and signed off, others were not. We raised this with the manager who advised that these were actions that were in the process of being completed. The electronic care recording system also allowed the manager to continuously monitor the care being provided and sent alerts to the manager where a care task had been missed. For example, if a person hadn't been supported to re-position at the correct time. This meant that the care provided could be monitored in real-time to reduce the risk of errors or omissions.

We found that further work was required to ensure records kept were detailed and accurate. For example, we found that some records lacked detail with regards to people's needs and how these should be met. Staff we spoke with displayed an in depth understanding of these needs but this was not reflected in care records. Additionally, the daily records maintained by staff through the hand held devices at times lacked detail. We raised this with the manager and the provider. They acknowledged that the records required further detail and advised they had identified this as an area for improvement. The provider informed us that further work was going to be undertaken to the electronic care record system to address this.

People were given the opportunity to feedback on their experience of the service through service user

meetings. We saw from records that people had been given the opportunity to discuss activities they would like to see with the activity co-ordinator. We also saw that a service user questionnaire had recently been given out and the provider was awaiting responses to these. People also told us that the manager and the directors would talk to them regularly and ask for their feedback informally. One relative told us, "Sometimes I don't know how [managers name] does her work. She can be chatting for hours!"

Both the manager and the provider were clear on their values and their vision for the service. One of the directors told us, "We want to grow, but not too big. We don't want to be corporate and uncaring". They also added, "I want to make sure I know our staff and the people living here. This is why I visit at least four times a week". The provider had clear plans to improve the quality of the service using innovative technologies to support care provision. They told us how their next wave of innovation included an auditing system that would provide an extra check on the audits already completed to ensure quality care was being provided.