

HC-One Limited

Ashgrove Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 24 and 25 January 2017 and was unannounced. At our last inspection in November 2015 we found that the provider 'required improvement' overall. We found concerns with the level of staffing, not enough activities being available for people and quality assurance checks on the service were not effective in identifying areas for improvement.

Ashgrove Nursing Home is registered to provide accommodation and nursing support for up to 57 older adults with a variety of health conditions including dementia. On the day of our inspection there were 47 people living in the home. There were 30 people living in the nursing unit with eight beds allocated as a short stay for people leaving hospital managed through the Clinical Commissioning Group (CCG) and 17 people living in the residential dementia unit. A manager had recently been appointed and was in the process of applying to register to manage the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

People felt safe within the service. Staff knew how to keep people safe and had received the appropriate safeguarding training to do so. There was insufficient staff to keep people safe within the dementia unit. People were administered their medicines as it was prescribed.

Staff had the skills and knowledge to support people appropriately. People were supported by staff in a way that ensured their human rights were protected within the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The provider needed to make improvements to how people knew what choices of meals were available to them, but people were able to get enough to eat and drink. Where people needed to see health care professionals this was available to them.

People had a mixed view as to whether staff were consistently kind and caring towards them. People's independence and privacy was respected, however we found that people's dignity was not always being respected. An advocacy service was not available to support people who needed to make choices and decisions as to how they were supported.

The provider had an assessment and care planning process in place which involved people in identifying their support needs. We found that people's support needs were being reviewed. While we found that people were able to take part in activities, this was not consistent or appropriately linked to their interests and hobbies.

The provider had a complaints process in place to enable people to raise complaints. We found that spot checks and audits were taking place by the manager and provider however these were not consistently effective in identifying areas of concern.

People were able to share their views on the service they received by completing a quality assurance questionnaire. We saw that where actions were identified these were being discussed with people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

We found that sufficient staff were not available within the dementia unit to support people safely.

People were administered their medicine as it was prescribed.

The provider ensured the appropriate checks were carried out before staff were appointed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

There was not a sufficiently clear menu to support people to make an informed choice at meal time.

The provider demonstrated how the Mental Capacity Act 2005 was implemented so where people lacked capacity their human rights were not restricted without the proper processes being followed.

People were able to access health care as needed.

Is the service caring?

Requires Improvement ●

The service was not always caring.

People had a mixed view as whether staff were consistently caring and kind in how they supported them.

People's privacy and independence was being respected by staff. Staff did not consistently ensure people's dignity was respected.

An advocate service was not available to support people to make decisions where needed.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

While the provider had taken action to reduce people feeling isolated, there was not sufficient activities linked to what people liked to do.

People were involved in the assessment, care planning and review process.

People knew how they could raise complaints.

Is the service well-led?

The service was not always well led.

We found that spot checks and audits were not effective in identifying areas of concern within the service.

People were able to share their views as part of a provider survey/questionnaire process being in place.

The recently appointed manager was actively working to improve the quality of the service people received.

Requires Improvement ●

Ashgrove Nursing 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 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.

Our inspection took place on 24 and 25 January 2017 and was unannounced. The inspection was conducted by one 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.

We asked the provider to complete 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from the Local Authority and the Clinical Commissioning Group. They both have responsibility for funding and monitoring the quality of the service. The information we were provided with we used as part of the inspection of this service.

We spoke to six people, six relatives, four members of staff and the cook. We also spoke to a health care professional who was visiting the service and the recently appointed manager. We looked at the care records for three people, the recruitment and training records for three members of staff and records used for the management of the service; for example, staff duty rosters, accident records and records used for auditing the quality of 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 could not talk with us.

Is the service safe?

Our findings

A person said, "I think there are enough carers [staff] but they [staff] don't come very quickly, they [staff] take a long time to come when I buzz [activate the call system]". A person said, "When I press the buzzer staff do not always come". Another person said, "There is never anyone [staff] here after tea time, no one". A relative said, "There is not enough staff on the dementia unit". Another relative said, "There seems to be less staff around to support people on an evening". Staff we spoke with had a mixed view on staffing levels. They told us there was enough staff on the nursing unit, but they needed more permanent staff as they were using a lot of agency staff. They also told us there was not enough staff on the dementia unit.

We found that the staffing levels on the dementia unit had not changed since our last inspection. We found during lunch time that where people needed support to eat and drink that there was not sufficient staff available to support people. People were therefore seen struggling to eat and drink. A staff member said, "We need more staff on a morning and after lunch time". A relative told us that there was not sufficient staff on the dementia unit in a complaint they raised with us after our inspection. There were a number of people who required two staff to support them at all times, this left not enough staff on the floor to ensure people in the lounge was monitored consistently. Where other people needed assistance there was not sufficient staff to support them timely. We raised our concerns with the manager who took action to increase the staffing levels on the second day of our inspection and told us that staffing levels would be increased permanently. The manager also confirmed they were currently recruiting more permanent staff.

Since our last inspection in November 2015 we found that the staffing levels on the nursing unit had been improved and a nursing assistant role had been developed. Staffing levels had also been improved which meant there were visibly more staff available to support people when needed. We found where people were being supported in their bedrooms that they had limited contact and support from staff in comparison to people in the lounge area. People in their bedrooms told us they went for long periods without seeing any staff. We saw no evidence in place to show how management ensured staff regularly checked people in their bedrooms or that staff had a process in place to ensure people were checked on a timely basis. We discussed how staff were being deployed with the manager. They told us that staff were required to see each person in the rooms at least once per hour to ensure they had something to drink. They would also look into developing a system of ensuring people in their bedrooms were being monitored as to how frequently they did see staff.

The provider had an appropriate procedure in place to guide and support staff to administer medicines safely. However we found that one of the medicine trolley's used to store and administer medicines from could not be locked. We saw during our observation of people being administered their medicines that the trolley was left unlocked and unattended. We raised this with the nurse administering medicines who told us the trolley had been broken since the previous day. We raised this with the manager and action was taken immediately so the trolley was no longer left in an unsafe manner.

A person said, "I get my medicines regularly, I am not always sure what it's for". A relative said, "I don't have any concerns with how medicines are being managed". We found that where medicines were being

administered staff had received the appropriate training and their competency to administer medicines was also being checked regularly which staff confirmed. We found that where people were administered medicines that a Medicines Administration Record (MAR) was being used to record what was administered and by which staff. Staff told us that they would only administer medicines that were prescribed and where people received medicines 'as and when required' the appropriate guidance was in place to support staff in administering this medicine. We also saw that these medicines were clearly identified on the MAR.

The staff we spoke with told us they were required to complete a Disclosure and Barring Service (DBS) check as part of the recruitment process before being appointed to their job. This check was carried out to ensure staff were able to work with vulnerable people. We found that the provider's recruitment process also included references being sought and the appropriate identity checks being carried out on potential new staff. We found that where nursing staff were employed that the appropriate checks were taking place to ensure these staff were appropriately qualified and registered with the Nursing and Midwifery Council.

A person said, "I do feel safe". Another person said, "I do feel safe, I didn't even worry for my safety when I was walking with the frame for the first time, I knew they [staff] were nearby if I needed assistance". A relative said, "I am confident my relative [person receiving service] is safe". Staff we spoke with were able to explain what action they would take where someone was at risk of harm. A staff member said, "I would report any abuse to the manager". Staff were able to demonstrate an understanding of how people should be kept safe and under what circumstances they would take action to keep people safe from harm. We saw that staff had received the appropriate training in safeguarding so they were able to recognise abuse and know what action to take and staff confirmed to us they had received this training.

The provider had a system in place to ensure risk assessments were taking place. Where there was a potential risk to how people were supported we saw that risk assessments were carried out to identify how the risk to people would be managed or reduced. Staff we spoke with were able to give examples of the types of risks they were currently managing. We found that where people were at risk of falls that a falls risk assessment was in place which identified how the risk should be reduced. For example we saw in one person's bedroom that a sensor alarm was on the floor to pick up any movement from the person so staff could respond quickly to reduce the risk of them falling. This was identified on the person's risk assessment and staff knew how to operate the equipment. We saw that other risk assessments were also being carried out to ensure the environment was safe, that medicines were being administered safely and that that risks to people choking were being managed safely.

We found that where an accident or incident had taken place that these were being recorded appropriately. We found that monitoring systems were in place to ensure that where there might be a trend to accidents or incidents taking place that this could be picked upon and action taken to reduce them. Staff we spoke with were aware of the processes in place for recording where an accident or incident had taken place. A staff member said, "Accident forms are in the nursing station and once completed are passed to the manager".

Is the service effective?

Our findings

A person said, "There is always plenty of food and a good choice of different dishes. The food is alright I can say that". Another person said, "The food is excellent, meatballs and pasta yesterday, stew or grilled salmon today. Plenty of choice". We found that people were being given a choice of meal. Staff were seen asking people what they wanted to eat. While we saw that a menu was in place the choices were not visibly being displayed to support people to make an informed choice. The menu we saw was in the reception area and the meals being displayed were not the meals people were being offered on the day of the inspection. This meant that people were not being given a real choice that was accurate and reflected the food on offer. The menus were only available in written format so where people would benefit from seeing the menu in a pictorial format this was not available. The manager told us they would look at bringing this in. We saw on a number of occasion's staff asking people who were clearly unable to make a decision what they wanted to eat. When the person did not make an informed choice a choice was made for them with no clear process as to how this was done. Staff did not know what people's preference was as to what they liked to eat.

We found that where people had specific meal requirements for example they needed food supplements or were diabetic that there were appropriate systems in place to ensure kitchen staff knew who these people were and what they were able to eat and drink. We spoke to the cook who was able to tell us the people who required a diabetic diet, who needed supplements or were on a specific diet. We found that systems were in place so where there was a requirement for people to be weighed regularly that this was being done and action taken where there was a concern identified.

A person said, "The staff are very good, I am very pleased with them, they look after me well, they know me well". A relative said, "The staff I have met all seem lovely and knowledgeable. They seem to know my relative [person receiving the service] very well". A staff member said, "I do feel supported in my job. I get supervision and I am able to attend staff meetings". Another staff member said, "I am able to get support when needed". We found that staff were able to access support when needed to ensure they had the skills and knowledge to support people and that there were systems in place to ensure staff received regular support by way of supervisions and staff meetings.

We found that staff were able to discuss their development needs by way of an appraisal system being in place. This led to staff being able to develop their skills and knowledge by accessing training over and above the regular training provided by the provider. They were able to access training where people had specific support needs like epilepsy or were at a risk of choking when they ate or drank. A staff member said, "I do get regular training". We found that as part of the induction process newly recruited staff were able to shadow existing experienced staff so they were able to get to know how people wanted to be supported before they started work on their own. While a staff member we spoke with told us they had not gone through the care certificate we found that the provider did have this available to newly appointed staff as part of their induction into the care sector. The care certificate was linked into the provider induction process, if this was not explained to staff they would not be aware. The care certificate sets out fundamental standards for the induction of staff in the care sector.

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

We checked whether the service was working within the principles of the MCA and whether any conditions for authorisations to deprive a person of their liberty were being met. We found that where people lacked capacity that the appropriate assessment had been carried out and where their liberty was being restricted that a DoLS had been approved or had been submitted to the appropriate supervisory body. Staff we spoke with were aware of any DoLS in place or had been applied for and why the person's human rights were being restricted. We found that where a DoLS had not been approved that the appropriate best interest decision making process was in place. Staff demonstrated a good understanding and told us they had received the appropriate training which we were able to confirm.

We saw people's consent being sought before staff supported them and where people were unable to give consent staff were able to make best interest decisions based on their knowledge of people or involved relatives to ensure what people's interest, likes and dislikes were taken into account as part of the process.

We found that people's health care needs were being identified appropriately. We found that where people needed to see a doctor, dentist or another health professional that people were able to do so and the outcome from these appointments were noted so staff could take action as required. Staff had a good understanding of people's health care needs. A health care professional told us the care people received was good and they had never had any cause for concern. That staff followed their instructions where people had specific support needs that needed health care intervention. We found that a number of people stayed at the service on a short term basis as part of funding made available from the Clinical Commissioning Group (CCG). The aim was for those people to go back home once they had spent a period of time in the service being rehabilitated. We found that staff knew what support these people needed and were able to explain how the support these people received was different to people living in the home on a permanent basis.

Is the service caring?

Our findings

A person said, "I think the staff do a good job; they [staff] are always thoughtful, asking if I am alright and if I need anything. It's the first nursing home I have stayed in and it's been alright so far", someone else told us, "All the staff have been lovely and very helpful. They help me get dressed and have a wash, got no problem with it at all, they [staff] are all really good". Another person said, "The staff are very good, if they can do anything for you they will. They [staff] look after me very well, sometimes I feel scared when I am sitting on my own and I wonder what's going to happen to me in the future, there are a few staff I can talk to though, they make me feel better just by having a chat". A relative said, "I am very happy with the care given so far and I am confident that my relative [person receiving service] is well looked after, she [person receiving the service] gets cold easily and they [staff] make sure she feels warm and I know she is settled as she is eating well and she looks happy". While we saw staff treating people in a caring, kind and compassionate manner some people were not so complimentary of the staff. This was due to staff not always responding to them promptly.

Staff we spoke with knew people's support needs and were able to demonstrate to us a good understanding of how people should be supported. We saw staff regularly approach people and sit and have a chat and check that they were okay.

We found that the provider had an equality and diversity policy in place and staff were able to get training in understanding equality and diversity, which staff confirmed. Staff knew what people's likes, dislikes, preferences, cultural needs and religious requirements were. This meant people's equality and diversity needs would be met.

A person said, "Staff keep my dignity at all times". We found that the provider had displayed the important elements of respecting people's dignity and they also had a member of staff nominated as a dignity champion. However we found that the way staff supported people did not always respect their dignity. We saw someone walking around with food debris on their clothes and face after lunch and staff did not ensure they were presentable to leave the dining room. We saw someone else whom staff were supporting to eat and drink being left in an undignified manner, after staff had just finished supporting them to eat and drink at lunch time. We saw people being encouraged by staff to do as much as they could for themselves so they could live as independently as possible. Staff we spoke with were able to show an understanding as to why people's independence, privacy and dignity should be promoted even though this was not always demonstrated. They were able to tell us about the dignity champion and what their role was in supporting staff to promote people's dignity. At our last inspection we found concerns with how people's dignity was being respected, while we saw some improvements to how people's dignity was respected on the dementia unit people's dignity was still not always being respected and adhered to on the nursing unit.

People made decisions as to how staff supported them. What people decided they wanted was how staff supported them. Staff told us their knowledge of what people like to do and relatives input would dictate how decisions were made where people lacked capacity. However we saw no evidence of an advocate service being available to actively support how people's views were gathered or how they were supported to

make decisions especially where they may not have any relatives. The recently appointed manager told us they were currently looking to bring in an advocate service within the home to support people to make decisions where they needed support.

Is the service responsive?

Our findings

A person said, "I haven't seen or heard anything about activities happening since I came". Another person said, "They [the provider] have singers come along sometimes and they do bingo". Staff we spoke with told us there were not many activities for people. We found that activities did take place but they were not structured and were not consistent. While people were able to take part in some activities for example they could sing along when the singer visited or play bingo, these activities were not linked to people's likes, dislikes or interests. We spoke to a recently appointed activities coordinator who showed us the plans they had already actioned to link activities to what people liked to do. People were being spoken with and a 'remembering together' book was being put in place to identify the things people like to do, their dislikes, preferences and life history. One person said, "They [staff] have spoken to me to find out what I like to do". We were able to confirm what we were told. We saw a display of activities and events that had taken place previously which demonstrated that people were able to socialise even if it was not on a consistent basis. The manager told us that two activities coordinators had recently been employed to put in place meaningful activities for people which we saw was being actioned since the previous coordinators had left.

We found that assessments and care plans were in place to show what people's assessed needs were and how people were to be supported. A person said, "I was involved in the assessment and care planning process". A relative said, "My father and aunt had meetings and were asked about my relative [person receiving service] support needs and we filled out forms". We saw assessments that had been completed prior to people being in the home and care plans showing the support people needed. We found that the documentation being used was being updated to reflect information more comprehensively. We saw review paperwork that had been completed which showed where people or their relatives were involved in the process by their signature. This showed that people's support needs were being reviewed to ensure the support they needed was what they were receiving.

A person said, "I would complain to the manager, but I am very happy with the care I get". Another person said, "If I was upset or troubled by anything I would talk to my family or complain to the manager". Staff we spoke with told us that any complaints they received would be passed to the manager to resolve. We found that the provider had a complaints process in place to deal with complaints, but they were only available in one format. Complaints were logged to show how they were handled and resolved. We found that complaints were also logged with the provider's head office so the monitoring of the complaints could take place and where appropriate trends analysed.

Is the service well-led?

Our findings

At our last inspection in November 2015 we found that while spot checks and audits were taking place they were not effective. We found from this inspection that there was still not sufficient improvements. The recently appointed manager was able to show evidence of spot checks they had carried out, however the poor staffing levels within the dementia unit had not improved. We did however find that the staffing requirements within the nursing unit had improved. We saw that medicine audits, checks on the environment within the home amongst a range of other checks and audits were taking place. While we found that the provider's representative carried out checks on the service provided their checks were also not effective in identifying the poor levels of staffing in the dementia unit.

Since our last inspection the registered manager had changed and a new manager had recently been appointed in December 2016 and was in the process of registering with the Care Quality Commission to be the registered manager. We found that not all people knew who the new manager was. People we spoke with told us the manager was not seen around the home checking on what staff were doing. A relative said, "I don't think I have seen the manager around, there doesn't seem to be anyone around to ask if we need to find anything out". Staff we spoke with told us the manager did walk about the home and checked on how they were supporting people. The manager told us they consistently walked about the home to check on how people were being supported by staff.

A person said, "Generally pretty happy staying here I will be glad to be back in my own home". Staff told us that the service was well led as the recently appointed manager was now making improvements to the home. We observed the atmosphere in the home to be warm, friendly and relaxed and staff were approachable. People appeared content and comfortable around them. Since our last inspection we found that people were not all just based in the lounge area sitting around a couple of televisions, but they were able to move around the home as they wanted. We observed staff sitting and chatting to people and having laugh. This was an improvement from our last inspection.

A person said, "I have had a questionnaire to complete". Staff we spoke with told us they were required to complete provider questionnaires about the service. We found that a questionnaire was used by the provider to gather people's views on the service. However depending on when the questionnaires were sent out people in the home on a short stay basis from hospital may not have completed a questionnaire. We saw that the provider analysed the information they received from the questionnaires and any planned actions were being shared with people.

We found that while a meeting had not happened for a while that people and their relatives were able to meet within the home as a way of them being able to share their views about the home with management and be kept updated on plans within the home. The manager told us a meeting was being arranged shortly now that they were now in post.

We found that the service had a 'resident of the day' process in place. This enabled all departments of the home to come together and ensure the quality of the service the person should receive was of a high

enough quality and that documentation and records were correctly in place and up to date. This ensured each person's care plan was monitored regularly to ensure consistency and to identify areas of concern.

It is a legal requirement that the overall rating from our last inspection is displayed within the home and on the provider's website. We found that the provider had displayed their rating as required.

We found that the provider had a whistle blowing policy in place. Staff we spoke with were able to demonstrate an understanding of the policy and its purpose. A staff member said, "I have seen the whistle blowing policy and I do know when it should be used".

The manager understood the notification system and their role in ensuring we were notified of all deaths, incidents and safeguarding alerts as is required within the law.