# Longhurst & Havelok Homes Limited

# Ashley Court

## Inspection report

1 Ashley Court
Boundary Street
Lincoln
Lincolnshire
LN5 8PQ

Tel: 01522539247
Website: www.landhhomes.org.uk

Date of inspection visit:
22 June 2016

Date of publication:
21 July 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This inspection took place on 22 June 2016 and was unannounced.

Ashley court specialises in the care of people who have a physical disability. It provides accommodation for up to 15 people who require personal and nursing care. On the day of our inspection there were 15 people living at the home.

At the time of our inspection 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.

On the day of our inspection we found that staff interacted well with people and people were cared for safely. The provider had systems and processes in place to safeguard people and staff knew how to keep people safe. Risk assessments were in place.  Medicines were administered and stored safely. Accidents and incidents were monitored and recorded.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).If the location is a care home Care Quality Commission is required by law to monitor the operation of the DoLS, and to report on what we find.

We found that people's health care needs were assessed, and care planned and delivered to meet those needs. People had access to other healthcare professionals such as a dietician and GP. Staff were kind and sensitive to people when they were providing support. Staff had a good understanding of people's needs. People had access to leisure activities and excursions to local facilities.

People had their privacy and dignity considered. Staff were aware of people's need for privacy and dignity.

People were supported to eat enough to keep them healthy. People had access to drinks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

There were sufficient staff available to care for people appropriately. A safe recruitment process was in place. Staff were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs.

Staff and people who lived at the home felt able to raise concerns and issues with management. We found relatives were clear about the process for raising concerns and were confident that they would be listened to. The provider recorded and monitored complaints.

Audits were carried out on a regular basis and action put in place to address any concerns and issues. People were involved in the improvement of the home.

## 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 consistently safe.

Staff had received training and were aware of how to keep people safe from harm.

Staff were aware of risks to people and knew how to manage those risks.

Medicines were stored and handled safely.

### Is the service effective?

**Good**

The service was effective.

Staff had received training to support them in their role.

People were involved in planning meals and were supported to eat a balanced diet. People were supported to access other health professionals and services.

The provider was meeting the requirements of the Mental Capacity Act 2005.

### Is the service caring?

**Good**

The service was consistently caring.

There was a warm and pleasant atmosphere in the home and staff were kind and caring to people. People were supported to be independent.

People's privacy and dignity was protected and staff were aware of people's individual need for privacy.

### Is the service responsive?

**Good**

The service was responsive.

People were supported to pursue leisure activities and participated in the local community.

People had their needs regularly assessed and reviewed. People were regularly involved in these reviews.

People were supported to raise issues and concerns. Relatives told us they knew how to complain and would feel able to.

## Is the service well-led?

Good

The service was well led.

Processes were in place to communicate with people and their relatives and to encourage an open dialogue.

Processes were in place for checking the quality of the service.

# Ashley Court

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 June 2016 and was unannounced. The inspection team consisted of an inspector and an Expert by Experience (Ex by Ex). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We also reviewed the information we held about this home including notifications. Notifications are events which providers are required to inform us about.

During our inspection we observed care and spoke with the registered manager, two senior care staff, seven care staff and five people who used the service. We also spoke with two relatives by telephone. We looked at three care plans and records of training, complaints, audits and medicines.

Requires Improvement

# Is the service safe?

## Our findings

People who used the service told us they felt safe living at the home. A person told us, "I don't feel vulnerable or anything like that. There's one (resident) I don't get on with but that's it, we just don't get on. No problem." Another person said, " I'm happy, safe, it feels like home." Relatives we spoke with told us that they felt their family member was safe.

Medicines were handled and administered safely and medicines were stored in locked cupboards according to national guidance. The provider needed to ensure that appropriate arrangements were in place for the management of medicines which were not prescribed for administration on a regular basis (PRN). Three people were supported to administer their medicines themselves. We saw that risk assessments had been regularly updated, for example, one person had made an error with their medicines and their risk assessment and care had been updated accordingly. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control. Staff told us that they received regular training on the administration of medicines. We saw from the records that staff had completed training. Medicine administration records(MARs) were completed fully and systems were in place to ensure that the member of staff who gave medicines could be identified. This facilitated a check in the event of a medicine error. Where people required 'as and when' (PRN) medicines this was not reflected in the MARs. For example, three people were prescribed paracetamol on an 'as and when basis' for when they experienced pain. We saw that the MARs did not specify this. there was a risk that medicines would be given when they were not required. We discussed this with the senior care staff who said they would discuss this with the prescribing GP.

Staff that we spoke with were aware of what steps they would take if they suspected that people were at risk of harm. Staff were aware of how to report an incident both internally and externally to the provider. They told us that they had received training to support them in keeping people safe. We saw from the training record that all members of staff had received this training. The provider had safeguarding policies and procedures in place to guide practice and regular reports were submitted to the local authority regarding any safeguarding issues and concerns. We looked at the information we held about the provider and saw that issues regarding safety had been reported appropriately.

Individual risk assessments were completed for people who used the service and included guidance on their care needs in order to manage the risk and promote their independence. For example, risk assessments were in place for people who required support with moving and for accessing community facilities. Staff were familiar with the risks and were provided with information as to how to manage these risks and ensure people were protected.

One person told us, "I always feel there's enough people [staff]." Another said, "□Staff come quickly if I need them." We found that there were sufficient staff on duty to meet people's needs. Staff told us that they felt there were enough staff available. Where additional staff were required in order to meet people's needs this

was provided. For example, on the day of our inspection additional staff had been provided to facilitate people to go out on a trip. We found that staff retention was good, this helped to support continuity of care for people. When there were gaps on the duty rota due to staff sickness these were filled by either staff on the internal bank or agency staff. When agency staff were used the provider obtained these from two agencies where the staff knew people who lived at the home. The provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. This was in place to ensure that staff were suitable to work with people. At the time of our inspection the home had one full time vacancy which they were in the process of recruiting to.

Good

# Is the service effective?

## Our findings

People received care from staff who had the knowledge and skills to carry out their roles and responsibilities effectively. Staff told us that they felt they received appropriate training to enable them to care for people. We saw a training plan was in place and had been updated to reflect what training had taken place and what training was required. Training was provided in a variety of methods for example, face to face and by computer. The training included statutory training such as fire and health and safety and also topics which were specific to people's needs such as human rights. The registered manager and a senior had also attended training to enable them to deliver training to staff. They said this would enable them to be more flexible around the provision of training in order to meet staff's needs.

We spoke with a member of staff who had recently started working for the provider and they told us that they were currently completing their induction. They told us that it included both training and shadowing shifts to ensure that they understood the needs of the people who lived at Ashley Court. The induction was in line with national guidance as the provider had recently introduced the Care Certificate. This is a new training scheme supported by the government to give care staff the skills needed to care for people. Supervision was provided on a regular basis and staff told us that they had received personal development reviews. Personal development reviews provide an opportunity for staff and managers to review performance and ensure that staff have the skills and support to carry out their role.

We asked about the food and one person told us, "Food is fab, it's brilliant. They always come with a choice of three, can get other stuff. I had a lovely tuna salad yesterday." Another person said, "You get what you want, it's good."

Where people had specific nutritional needs we saw that plans and assessments were in place to ensure that their needs were met. For example, one person told us that they were being supported to manage their weight. They told us that they had attended a group to assist them with this and that the cook was very helpful in providing appropriate meals. They said, "[Cook] is helping with my diet. She's very good at sorting me food."

We observed lunchtime and saw that staff provided support and assistance to people in a sensitive manner in order to ensure that people received sufficient and appropriate nutrition. Lunchtime was relaxed and unhurried. Staff sat with people and chatted with them, for example, about their plans for the rest of the day. People had access to drinks and snacks during the day. A daily menu was available and those who did not like the food choice for that day were able to have an alternative. We observed the cook asking people what they would like for their meals during the afternoon. Where people required specialist equipment to support them with their meal this was provided and detailed in the care record.

A relative told us, "It's wonderful, the care, the attendance, they're there all the time. If [relative] is not well they get a doctor in quickly." We found that people who used the service had access to local healthcare services and received on-going healthcare support from staff. The registered manager told us that they had

a positive relationship with the local GP practice and district nurses. Physical health assessments had been carried out and we saw that people had accessed health screening. The provider had made appropriate referrals when required for advice and support. Where people had specific health needs such as the need for catheter care this was clearly detailed in care records.

We saw records of appointments and intervention from other professionals in the care records such as occupational therapy and dentist. People had transfer documents in place which included information about people's health needs so that if they were admitted to hospital or needed to attend a clinic, information was readily available to ensure that they received appropriate treatment.

Staff understood about consent and told us that they would always seek people's involvement in consenting to care. Where people required health interventions appropriate consent had been sought. Where people declined care this was appropriately documented and plans for management of the risks were in place. For example, a person refused to use a lap belt in their wheelchair and a record of this was included in their care plan with an accompanying risk assessment.

Where people did not have the capacity to consent, the provider acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it is judged that a person lacks capacity a person making a decision on their behalf must do this in their best interests. We observed meetings had taken place which involved a range of people including the local authority and people's representatives to consider what was in people's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. At the time of our inspection no one was subject to a DoLS.

Good

# Is the service caring?

## Our findings

People who used the service and their families told us they were happy with the care and support they received. One person said, "We have some nice staff here." Another person said, "Staff are fabulous, really caring, always ask what you want to do, what you want to wear, never assume." A staff member said, "People are number one priority here." Another told us, "It's like a family her." A relative said, "They (staff) all know us, know the family, we've never had any upsets. They don't leave you out of anything, it's one big, happy family."

We saw that staff interacted in a positive manner with people and that they were sensitive to people's needs. Care was supportive and enabling, as befitted the needs of the individual residents. People were treated as individuals and allowed to express their views as to how their care was provided. For example, when we arrived at the home at 10 am some people were still in bed according to their choice. We saw when people asked for assistance staff responded in a prompt and kindly manner. We saw that caring relationships had developed between people who used the service and staff. Residents repeatedly described staff in very positive and caring terms and words like "family" were used. Equally, family members said that they were well known and well received by the service. Staff knew people's individual preferences and were able to interpret their needs when people were unable to communicate verbally. For example, we observed a person having difficulty swallowing their medicines and the member of staff realised this and gave assistance in order to resolve the problem for them. During lunchtime we observed a person who was being assisted with their meal suffered a minor choking episode which was dealt with professionally and calmly by staff.

People were encouraged to participate in their care. For example, there was a facility for people to cater for themselves. We saw in one person's record they preferred to make their own breakfast and another person used the facility to bake with support from staff. Another record stated, 'I like to have a shower as and when required.' We found that the care planning process centred on individuals and their views and preferences. We saw that care records included people's choices about how they wanted their care to be provided and included information regarding people's independence. For example, a care record stated what product a person preferred to use to wash their hair with. Another record stated, "I would like to be there when my room is cleaned." People told us that their choices were respected and their care plans reflected their preferences. Where three people had chosen to self medicate we found that the care plans which related to medicines were not always clear that people were being supported to manage their own medicines. The care plans were used to guide staff which meant staff could have provided care which people had not agreed to.

People had access to advocacy services. People were provided with information on how to access an advocate to support them through complex decision making, such as managing financial affairs. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes. A person told us, "Privacy and dignity is okay when anyone helps. There's a male carer and that's not a problem for me, everyone is just fine." Staff we spoke with understood what privacy and dignity meant in relation to supporting people with personal care. Staff spoke discreetly to people and

we observed staff knocked on people's bedroom doors before entering and asked if it was alright to come in. We saw that the system for medicine administration allowed for people's privacy and dignity to be protected. Medicines were kept in people's bedrooms which meant that medicines were usually administered in people's bedrooms unless they requested differently. This allowed staff to discuss personal issues in a confidential manner and provide any support necessarily discreetly.

The registered manager told us they were in the process of setting up a dignity group made up of people who lived at the service, a relative and a staff member. They said that the group would be about ensuring that people were treated with dignity and challenging practice. They told us that the group would ensure that people's views about privacy and dignity were taken into account and continued to be a high profile in the delivery of care. We saw in records that people had already been asked about their experiences about dignity in the home and as a result the group had been developed to increase discussion and action on the issue.

We saw that staff addressed people by their preferred name and that this was recorded in the person's care record. Bedrooms had been personalised with people's belongings, to assist people to feel at home. We saw that there were areas around the home where people could be private if they wished.

Good

# Is the service responsive?

## Our findings

People told us they were supported to access plenty of varied activities. One person told us, "I go on my own to the stroke club once a month. Mondays I do pottery at the day centre. I love it. I do art as well." A relative told us, "[Our relative] can go out solo but if in just an ordinary chair someone will take him to the pictures or to Skegness."

On the day of our visit some of the people were attending the Lincolnshire Show. Another person had been to the England cricket match the previous day. Staff told us about people's individual interests and how they were supported to follow these. For example, one person supported a local football team and was a season ticket holder, staff from the home supported them to attend the matches on a regular basis. Another person enjoyed playing the drums and was going to a drumming group that evening. They told us that they went regularly and enjoyed this activity.

Staff that we spoke with were knowledgeable about people's likes, dislikes and the type of activities they enjoyed and supported people to access these as they chose. Activities within the home were not provided on a planned basis. Instead people were encouraged to access activities and leisure pursuits according to their need and wishes. For example, one person chose to attend a day centre but another person preferred to go into town for lunch. We saw that people accessed both local facilities and clubs and enjoyed a wide range of activities. The home also provided some group events such as themed meal evenings and special events. People had been encouraged to express their choices in relation to group activities, for example, discussions had taken place at a meeting about possible outings.

Relatives we spoke with told us that they felt welcomed at the home when they visited their family member and that people were supported to keep in regular contact if they wished to by telephoning or visiting their relative. Facilities were also available for people who travelled long distances such as meals and accommodation. A relative told us, "We visit and make of a day of it, stay overnight in a room upstairs rather than drive home." The registered manager told us that they tried to ensure that feedback was provided to relatives on significant issues with the person's agreement. One person had recently suffered an accident and we saw that their family member had been informed as requested in their care record. Another person told us that their relative's visited and were able to stay in a guest room. They said this made it easier to keep in contact because they lived a distance away.

Reviews of care plans were carried out with the person, other professionals and relatives if people wished. People we spoke with knew about their care plans and what was in them. One person said, "We're shown our care plans" and "I very rarely look at mine but I know what's in it." The registered manager told us that people were involved in compiling and reviewing their care plans. We saw in the records evidence of discussions with people about their care. The registered manager told us that staff supported people to revise and review their care plans regularly by checking with them that their care plans reflected their needs. We looked at care records for people who used the service. Care records included risk assessments and personal care support plans.

We saw that care records had been reviewed and updated on a regular basis which ensured that they reflected the care and support people required. Where people's needs changed this was discussed at regular handover meetings to ensure that staff were kept up to date with people's changing needs. A member of staff told us that they found these very valuable.

The people we spoke with told us that they had their choices and views respected. For example, people were able to choose who they would like for their key worker. When we spoke with people they were all very happy with the keyworker they had and the support they received. People were also asked if they had a preference for a male or female carer. We saw that for some areas of support people had specified who should provide the care. For example, one person (female) who received assistance with bathing, had requested where possible, to have the support of a female staff member. In addition people had been given the opportunity to be involved in the recruitment of staff on an informal basis. As part of the process they were encouraged to share their opinions.

A survey had been carried out with people who used the service, professionals and their relatives to understand their opinions about the service. People told us about a telephone number which they could use to raise concerns and complaints if they wished to. Relatives told us that they would know how to complain if they needed to but that they hadn't had cause to do so. The manager kept a log of complaints and reviewed this on a regular basis in order to identify and trends. At the time of our inspection there had been no recent complaints.

Good

# Is the service well-led?

## Our findings

We found that the registered manager was visible, knew their staff and the people in their care. The people who used the service and their relatives that we spoke with knew who the registered manager was and knew them by name. One person said, "We're good here." Another told us, "We have a good manager." A relative told us, "Management are brilliant, very responsive."

Staff told us that they enjoyed working at Ashley court. They told us that they thought there were good communication arrangements in place which supported them in their role. Staff understood their role within the home and were aware of the lines of accountability. Staff told us that they would feel comfortable raising issues with the registered manager and the provider and felt supported by the registered manager in their role. Staff meetings were held regularly. In addition staff told us that the daily handover also gave them opportunity to discuss issues and changes within the home.

The provider encouraged regular feedback and used a variety of methods to ensure that people, relatives and visitors were able to comment on the service. Methods included questionnaires and meetings. These had been carried out with people who used the service, professionals and their relatives. The registered manager told us that the meeting for people who lived at the home was held on a monthly basis. They told us that the agenda was displayed on a notice board so that people could add to it any issues they wanted to raise. The explained that issues such as refurbishment were discussed at every meeting. They told us that people were encouraged to have a 'wish list' of improvements they would like so that when money became available they had been involved in deciding how to spend it to improve their home. They said that currently people were in the process of choosing new dining room furniture.

The registered manager had also developed a quality meeting which included a person who lived at the home, a relative and a member of staff. The aim of the group was to initially develop questionnaires for stakeholder, relatives and people who lived at the home which were meaningful and would result in driving forward improvements in the home. They said that when the responses to the questions were received the group would be responsible for putting the action plan together and the registered manager would be held accountable to the group for the completion of these.

The registered manager told us they were responsible for undertaking regular checks of the home. Checks had been carried out on areas such as infection control and health and safety. We saw the records of the checks identified when action were required. For example the registered manager had identified a number of minor errors in the MARs, we saw that as a consequence of these a system of checking had been implemented after medicines had been administered and the issues discussed at staff and residents meetings. As a consequence we observed that the frequency of these errors had reduced. Care records had also been checked to ensure that they included the required information to ensure that staff were able to care for people appropriately.

The registered manager said they were well supported by the provider. They told us about the plans they had for developing the service in order to provide additional facilities such as a flat for people who wanted

to live more independently.

A whistleblowing policy was in place. We saw that contact numbers were in place to report issues and were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed. They told us they felt able to raise concerns and issues with the registered manager. The relatives we spoke with told us that they would be happy to raise any concerns they had.