Lifestyle Care Management Ltd

Ashmead Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

We conducted an inspection of Ashmead Care Centre on 30 June 2016. The inspection was unannounced. At our previous inspection in November 2015, we found breaches of regulations relating to consent, nutrition and dignity and respect. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these areas.

We undertook this focused inspection to check the provider had followed their plan and to confirm that they now met legal requirements in relation to the breaches found. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashmead Care Centre on our website at www.cqc.org.uk.

Ashmead Care Centre is a care home with nursing for older people with dementia and/or nursing needs. There were 110 people using the service when we visited.

There was a registered manager at 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.

At our previous inspection we found the provider was not meeting the requirements of the Mental Capacity Act 2005. We saw examples of documentation being signed by next of kin without them having the legal authority to do so and some people's liberty was being unlawfully deprived. At our recent inspection we found most people either had applications in place authorising the service to deprive them of their liberty, or pending with the local authority. Where people did not have capacity to consent to their care we found documentation authorising someone to do so on their behalf in accordance with legislation. However, we found one example of someone being unlawfully deprived of their liberty without the service having the required authorisation in place.

At our previous inspection we found procedures were in place to protect people from abuse. However, staff understanding of how to recognise abuse varied and some staff were not aware of the provider's whistleblowing procedure. At our recent inspection we spoke with six care workers and two nurses and tested their understanding of safeguarding and whistle blowing procedures. Staff were aware of how to recognise abuse and knew the provider's whistle blowing procedure and when it should be used.

At our previous inspection we found medicines were administered, recorded and stored safely. However, we saw some creams did not include the date of opening or expiry date and some creams were in other people's rooms which increased the risk of cross contamination. At our recent inspection we found creams were for individual use and were stored correctly in people's rooms. We saw creams were marked with the date of opening and the date at which they were required to be disposed of.

At our previous inspection we found staff demonstrated an understanding of people's life histories and current circumstances and most staff supported people to meet their individual needs in a caring way. However, we saw varying levels of interaction between care workers and people using the service. At our recent inspection we found a good level of interaction between care workers and people using the service. Care workers took time to speak to people and to respond appropriately to their needs.

At our previous inspection we found people had care plans in place that reflected their assessed needs, but not all care records were updated as people's health needs had changed. At our recent inspection we found care records were updated in accordance with people's changing health needs and provided an up to date account of their requirements.

At our previous inspection we found auditing systems did not identify the problems we found. At our recent inspection we found auditing systems to be thorough and identified issues where required. We saw evidence of appropriate actions taken to rectify issues.

During this inspection we found a breach of regulations in relation to consent. You can see what action we told the provider to take at the back of the full version of the report.

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

We found action had been taken to improve how safe the service was. Procedures were in place to protect people from abuse. Staff had a good understanding of how to recognise abuse and were aware of the provider's whistleblowing procedure.

The service had adequate systems for recording, storing and administering medicines safely. We only found creams in people's rooms that belonged to them and these included the date of opening and the date of disposal.

Is the service effective?

Requires Improvement

We found some action had been taken to improve how effective the service was. However, the service was still not consistently effective. The service was not meeting the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments and Deprivation of Liberty authorisations were usually in place as required. However, we found one example where a person was being restrained to provide them with essential care. However, there was no DoLS authorisation in place permitting staff to do this and staff had not received training in safely restraining people.

Care workers demonstrated a good level of knowledge about the MCA and understood the issues surrounding capacity.

After our previous inspection we received a complaint about the food available at the service. We received good feedback about the food available and found the food to be appetising.

Is the service caring?

Requires Improvement

We found action had been taken to improve how caring the service was. People using the service gave good feedback about the care workers.

We saw good levels of interaction between care workers and people using the service. People's privacy and dignity was respected.

We could not improve the rating for caring from requires

improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found action had been taken to improve how responsive the service was. Care plans were updated to reflect people's changing needs.

We could not improve the rating for responsive from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

We found action had been taken to improve how well led the service was. Quality assurance systems had been improved and identified issues.

We could not improve the rating for well led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Ashmead Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 30 June 2016. The inspection was unannounced. The inspection team consisted of one inspector.

Prior to the inspection we reviewed the information we held about the service which included the provider's action plan. We contacted a representative from the local authority safeguarding team to obtain their feedback.

We spoke with six care workers, two nurses, the clinical lead who was the most senior nurse working at the service and the registered manager. We also spoke with five people using the service. We looked at a sample of 11 people's care records and records related to the management of the service.

Good

Is the service safe?

Our findings

At our previous inspection we found the provider had a safeguarding adult's policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated an understanding of how to recognise abuse. However, some staff were not clear on the procedure to follow if they suspected abuse was taking place. For example, we spoke with two nurses and only one could explain that safeguarding concerns were to be reported to the local authority for investigation.

During this inspection we found staff knowledge of safeguarding procedures was clear. We spoke with six care workers and two nurses and all were aware of the procedures to follow if they suspected abuse was taking place and that safeguarding concerns were to be reported to the local authority for investigation.

At our previous inspection we found that whilst the provider had a whistleblowing policy in place, some staff did not know about this and did not understand what whistleblowing involved. Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

At this inspection we found staff were aware of what whistle blowing involved and what the purpose of whistle blowing was. Comments from care workers included "It's about reporting concerns confidentially. There is a chain that I can go up if I don't think I'm being listened to" and "It is about reporting any poor practices. We are encouraged to report things that aren't right."

At our previous inspection we found people had equipment in place according to their needs. For example, some people with mobility problems used hoists and we saw records that demonstrated that these were serviced regularly. However, whilst we were told that slings were for people's individual use, we saw slings in people's rooms that did not belong to them. This meant that people may have been using slings that were not the correct size and therefore a risk to their safety. We reported this to the registered manager and deputy manager and they told us they had taken action to rectify this.

At this inspection we found people who required a sling had their own sling in their room which was clearly marked with their name. This ensured that slings could not be mixed up.

At our previous inspection we found MAR charts included details of creams people were using. We checked some of the creams in people's rooms. We saw that some creams did not include the date of opening or expiry date and some creams were in other people's rooms. This meant there was a risk of cross contamination from people using creams which did not belong to them.

At this inspection we found people only had access to their own creams which were kept in their rooms and clearly marked for their own use. We found creams were marked with the date of opening and with the expiry date so these could be disposed of when needed. We spoke with the lead nurse for one floor and they told us they ensured they reordered creams in advance so people had access to creams once old creams

were disposed of.

At our previous inspection we found individual protocols were in place for some "as required" (PRN) medicines, but we did not see a protocol in place in one chart for a person's PRN medicine. At this inspection we found protocols were in place for all PRN medicines we saw. Care staff were aware of the need to have these in place.

Requires Improvement

Is the service effective?

Our findings

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 are called the Deprivation of Liberty Safeguards (DoLS).

At our previous inspection we found examples of people's rights not being observed under the MCA. For example, we saw care records of three people who were deemed to have fluctuating capacity who had bed rails in place. We did not see evidence of this decision being made with their consent and there was no evidence of a mental capacity assessment, best interests decision or DoLS authorisation in respect of this. We also saw on some units within the building that exit was via a key pad. This meant that people were not able to leave the building without asking staff for the code. We saw numerous examples of mental capacity assessments in respect of people's decision to leave the building within their files, including the person we observed requesting to leave. All these assessments concluded that people did not have the capacity to leave the building on their own. However, there was no evidence of a best interests decision or a DoLS authorisation allowing staff to restrict their movement.

At our recent inspection we found almost all people whose movement was being restricted were either the subject of a DoLS authorisation or had an application pending with the local authority. However, we found one example of a person who was being restrained in order to be provided with essential care. We saw from this person's care record that senior staff had liaised with the Behaviour and Communication Support Service about meeting this person's needs. However, we did not see evidence of a specific risk assessment or a DoLS authorisation allowing staff to restrain this person. Care staff had also not undergone the requisite training to ensure they were able to restrain the person safely. We explained these issues to the registered manager and they assured us they would take action immediately to address these.

This meant that the provider was still in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we saw numerous examples of documentation in people's care records being signed by their next of kin. This included advance care plans which recorded people's end of life wishes and consent forms for the taking of photographs as well as care plans. However, there was no indication on the documentation as to whether the next of kin had Power of Attorney in respect of the person's health or welfare making them legally able to make decisions in their relative's best interests. At this inspection we found where people did not have capacity to consent to their care we found documentation authorising someone to do so on their behalf in accordance with legislation. We saw documentation from people who had Lasting Power of Attorney in respect of health and welfare decisions to demonstrate this.

At our previous inspection we checked whether the service was working within the principles of the MCA, and found that the provider was not meeting the requirements of the MCA. Most staff were not able to demonstrate that they understood the issues surrounding consent. When we explained the meaning of capacity, staff told us they had not had any concerns about people living at Ashmead Care Centre. Some staff were unable to explain what they would do if they suspected someone was making a decision without having the capacity to do so.

At this inspection we found staff were able to demonstrate an understanding of the issues surrounding consent. Staff were aware of the meaning of capacity and explained what they would do if they suspected people were making decisions without having the capacity to do so.

At our previous inspection we found that where monthly monitoring was required to ensure people's health needs were met, for example monthly weight checks, this was done and recorded. However, we saw some examples of food and fluid charts not being fully completed. Although we saw fluids were regularly offered and available throughout the day, we could not be fully assured that people's fluid and nutrition intake was adequately monitored as a result of these incomplete records. This may have put people at risk of their nutritional needs not being met as staff would not always have accurate information to hand about people's fluid and food intake and therefore would not know whether they needed to encourage further intake to meet their needs. At this inspection we found that where required, people's food and fluid intake was recorded and up to date. Where issues were identified appropriate follow up actions were taken which included referrals to the dietetic or speech and language therapy teams. We saw evidence that advice was recorded and actioned appropriately.

After our previous inspection we received a complaint about the food being provided at Ashmead Care Centre. At this inspection people told us they liked the food available. Comments included "The food is very nice" and "I enjoy the meals here." We spoke with the chef about the food available. They explained that they obtained feedback about the food from the care workers who relayed people's views. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and we saw two different choices of food were offered for every meal. For example we saw a beef stew and vegetarian noodles were offered for lunch as stated on the menu. We sampled the lunch and found it to be appetising, of a good portion and served at the correct temperature.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection people who used the service gave mixed feedback about the care they received. At this inspection, people gave good feedback about the care. Comments included "The carers are good. They try to help", "They are angels" and "They are nice people here- they take care of me."

At our previous inspection we found that staff did not always respect people's privacy. We observed staff entering people's rooms without knocking or introducing themselves first which did not respect people's right to privacy. At this inspection we found staff knocked on people's doors before entering their rooms and interactions we observed demonstrated a respectful and caring attitude towards people.

At our previous inspection although we found staff demonstrated a good understanding of people's life histories we saw varying levels of detail recorded in people's care records. At this inspection we found detailed records with people's life history recorded. We saw evidence that senior staff had asked detailed questions to prompt people's memories and to learn specific details about people which were important to them.

At our previous inspection we saw varying levels of interaction from care workers with people using the service. Some interactions we observed and conversations we overheard demonstrated that staff knew people well and were on friendly and familiar terms. However, we also observed two care workers not engaging with people at all, despite providing them with one to one care which meant people were not always provided with social interaction and reassurance from staff when being supported.

At this inspection we found good levels of interaction between care staff and people using the service. Conversations we overheard were friendly and light hearted and demonstrated that care workers were on good terms with the people they were caring for.

Although we found that concerns had been addressed, sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we saw three specific care plans which had not been updated as required when people's health needs had changed. For example, one person had been suffering from frequent urinary tract infections, but we did not see appropriate advice detailed in how to manage this. Another person's care record stated that they were continent, yet their monthly review stated that they were now incontinent. There was no update to their care plan in how to manage this although staff were aware of the change in this person's condition.

At our current inspection we found care records were updated in accordance with people's changing health needs and provided an up to date account of their requirements. Care records were divided into 16 sections, which included 13 care plans with associated risk assessments in areas such as 'personal care and physical wellbeing', 'diet, weight and dietary preferences' and 'sight, hearing and communication'. Care plans included a record of 'identified needs' which had been established following specific risk assessments, 'expected outcomes' and 'monthly evaluations'. For example, in the 'diet, weight and dietary preferences' section we saw consistent evidence of monthly nutrition and hydration assessments completed which identified specific needs with the person's diet. This was followed by a monthly MUST assessment which identified whether people were at risk of malnutrition and a 'diet and weight form' which included details about people's dietary preferences. The information from these monthly assessments was used to populate a comprehensive care plan which was also reviewed on a monthly basis. Where required there was evidence of up to date input from healthcare professionals such as dietitians or speech and language therapists and their input was also incorporated into the care plan.

Care plans were comprehensive and up to date, reflecting people's current needs.

Although we found that concerns had been addressed, sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we saw evidence of numerous audits covering a range of issues such as people's weight, pressure sores, medicines, falls management and infection control. These included an action plan. A further quality inspection was also conducted by senior staff within the organisation on a quarterly basis which assessed compliance with CQC regulations. Most audits appeared to be thorough, however, we noted that auditing of compliance with the Mental Capacity Act 2005 did not identify the issues we found because this did not include a check of documentation. In addition, the provider had failed to identify other issues we found during our inspection such as the infection control risk posed by use of creams for individuals, the incomplete food and fluid charts, care plans that had not been updated and staff behaviour in relation to the privacy of people using the service.

At this inspection we found the provider had adequate systems to monitor the quality of the care and support people received. We saw evidence of various audits in areas including 'topical creams' and 'care plans'. Where issues were identified we saw records of actions taken to rectify these. We also saw a comprehensive quarterly audit conducted by a compliance manager within the organisation. This included a detailed action plan to rectify issues identified.

Although we found that concerns had been addressed, sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 in circumstances where service users may have lacked capacity to consent to decisions regarding their care (Regulation 11(3)).