Ms Cherie Reynolds

Ashgrove Care Home

Inspection report

Church Lane
Oswestry
Shropshire
SY11 3AP

Tel: 01691774101

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection was carried out on 16 and 24 October 2017 and was unannounced.

Ashgrove Care Home is registered to provide accommodation with personal care for up to a maximum of 10 older people. There were two people living at the home during our inspection, visit however shortly following this the provider confirmed that both people had moved out of the home.

The provider is registered as an individual and therefore is not required by law to have a separate registered manager. 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 last inspection on 5 and 6 June 2017, we found the provider was in breach of the Regulations of the Health and Social Care 2008 (Regulated Activities) 2014. We gave the service an overall rating of requires improvement. The breach related to the provider's failure to ensure good governance. We asked the provider to send us an action plan to tell us how they would make these improvements by the 7 September 2017. Despite several contacts with the provider requesting their action plan we did not receive it prior to this inspection.

The service was not well-led. The provider lacked knowledge and understanding of the care regulations and their requirement to comply with them. There was a lack of effective systems to monitor the quality and safety of the service and to drive improvements.

There was a reduction in staff employed at the home and the provider was considering extending their service user band to include people living with dementia. We were not confident that staffing arrangements in place would support changes in people's needs or the needs of new people who may wish to live in the home.

The provider was unable to demonstrate what, if any, learning they took from accidents to prevent them from happening again.

There was a lack of effective systems in place to identify and monitor staff training needs. Not all staff had received training that was relevant to their roles and responsibilities.

The provider had not sought advice on person-centred care planning as recommended. We found that people's care records did not record their involvement in care planning and reviews. However, people felt staff knew them and their preferences well.

The provider had not conspicuously displayed their ratings from the latest inspection at the home as they are required to do by law.

People were satisfied with the choice and quality of food available to them. Staff were aware of people's dietary needs and monitored what people ate and drank to ensure people's nutritional needs were met.

People were supported to take their medicines when they needed to. Staff monitored people's health and arranged healthcare appointments as necessary.

Staff sought people's consent before supporting them and enabled them to make their own decisions.

People found staff to be kind and patient and enjoyed positive working relationships with them. People were given choice and felt listened to. Staff treated people with dignity and respect and encouraged them to maintain their independence.

People had not had cause to complain but felt confident and able to raise concerns should the need arise.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe.

The provider did not employ sufficient numbers of staff to support changes in people's needs or the needs of new people coming into the home.

The provider was unable to demonstrate what, if any, learning they took from accidents to prevent them from happening again.

The provider did not ensure all staff were trained and competent in managing medicines safely.

People felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not ensure that staff received all the training relevant to their roles and responsibilities.

People enjoyed the food and were able to choose what they would like to eat and drink.

Staff sought people's consent before supporting them and enabled them to make their own decisions.

Staff monitored people's health and arranged healthcare appointments for them.

Is the service caring?

Good

The service was caring

People received care from staff who were patient and kind.

People were offered choice and felt listened to.

Staff treated people with dignity and respect and encouraged them to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

The provider had not sought advice on person-centred care planning and there was still room for improvement in information recorded in people's care plans.

People were supported by staff who knew them and their preferences well.

People had not had cause to complain but felt comfortable to raise concerns with staff or management should the need arise.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was ineffective leadership at the service. The provider lacked the skills and knowledge about the regulations and their requirement to comply with them.

There was lack of effective systems to monitor the quality and safety of the service and to drive improvements.

People and staff felt that the provider was approachable.

Ashgrove 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 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.

The inspection was prompted in part by notification of a safeguarding incident. This incident is subject to a criminal investigation and, as a result, this inspection did not examine the circumstances of the incident.

This inspection took place on 16 and 24 October 2017 and was unannounced. The inspection was conducted by one inspector.

As part of the inspection, we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service. We used this information to plan the inspection.

During the inspection, we spoke with two people who lived at the home. We spoke with three staff which included the provider, the deputy head of home and one care staff member. We viewed two records which related to the assessment of people's needs and risk. We also viewed other records which related to the management of the service such as medicine records and accident reports. We spent time observing how staff supported people and how they interacted with them.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, the provider disputed that a fall a person had was an accident and had not recorded it as so. They were unable to demonstrate what, if any, action they had taken to reduce the risk of reoccurrence. At this inspection, we saw that staff had recorded an accident where a person had fallen when they had gone to the toilet by themselves. We found that staff had not followed the guidance in the person's risk assessment where they were required to accompany the person when they walked with their frame. The staff member was in the staff room when the accident occurred and there was no call bell available to enable the person to call for assistance. When we spoke with the provider and staff they were unable to tell us what action they had taken to prevent this happening again.

The person had sustained a head injury when they fell and whilst we saw in the person's care records that staff had cleansed the person's injuries, they had not sought advice from the GP until the following day. This had not impacted on the person's health and wellbeing but showed a lack of understanding of the implications that can occur with a head injury and the risks associated with this.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe with the support provided by staff. One person told us they felt reassured that staff were available to support them, if need be, when they had a bath. They said, "I like [staff member's name] to be there." Staff told us they kept people safe by ensuring a safe environment. One staff member told us they ensured outside doors were kept locked and put up wet floor signs when they were cleaning to alert people to slip hazards.

The deputy head of care told us they checked for any hazards when they cleaned the home. They showed us that they continued to report any faulty equipment or hazards in a maintenance book. This information was shared with the provider and once jobs had been completed these were checked off.

At our last inspection, we found that the provider had reduced the care staff's hours and was covering all the night shifts on their own as well as some of the day shifts. Since our last inspection two staff had left and there were only two staff and the provider working at the home. The two remaining staff told us they respectively worked an average of 16 and nine hours each week. This meant the provider was continuing to cover all the nights and a significant number of day shifts. While the two people living at the home had low levels of needs, one person required support with personal care during the night. When we spoke with the provider about the excessive hours they were completing they told us, "I have to do this. I have no other choice. It would be different if I had more residents." They went on to explain that they checked on the people every two to three hours during the night and were able to sleep in between these checks. The provider told us they were considering extending their service user band to include people living with dementia. We were not confident that staffing arrangements in place would support changes in people's needs or the needs of new people who may wish to live in the home.

People were supported by staff who were knowledgeable about the different forms of abuse. They were able to tell us how they would recognise the signs of abuse, such as bruising and changes in people's behaviours. They told us they would not hesitate to report concerns to the provider and that they knew they could also contact outside agencies. The provider told us they would report any concerns of abuse to the local authority safeguarding team.

People told us staff supported them to take their medicines when they needed them. We saw that accurate records were maintained and that medicines were stored safely.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that the provider did not have effective systems in place to monitor staff training and development. The provider had told us in the previous three inspections that they were going to arrange for staff to receive training relevant to their roles and responsibilities. At this inspection we found that one staff member had not received training in key areas relevant to their role, such as safe management of medicines, food hygiene, first aid and moving and handling. Due to low occupancy levels at the home, staff worked alone on shift. Therefore, this staff member was often required to administer medicine, cook meals and deal with any emergencies which may require first aid and/or moving and handling. The provider had no written records of medicine competency assessments being completed for staff. We asked them how they assured themselves that staff were safely administering medicines. They told us they would not allow the staff member that had not had training to administer any medicine other than paracetamol. They said, "I just thought there was no harm in paracetamol." This meant the provider had not ensured all staff were suitably trained and competent in their roles.

The remaining staff member had undertaken training of their own accord and at their own expense following the gaps in training we identified in our previous inspections. They told us, "Any training we are doing is off our own backs." They went on to say, "If it is something [provider's name] has to pay for, our hands are tied." The provider was also unable to provide us with any evidence of training they themselves had undertaken. We found significant gaps in their knowledge in relation to equality and diversity and safe moving and handling.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. The two care staff we spoke with showed an understanding of the MCA and the impact this had on their practice. One staff explained that they always sought people's consent before supporting them.t. They said, "I talk to them and explain things." They went on to say they gave people options and if the person did not understand, they worded things differently to enable them to make decisions for themselves.

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). At the time of our inspection, no one living at the home was subject to a DoLS authorisation. When we spoke with the provider we found that they lacked an appropriate current understanding of the implications of MCA and DoLS. They told us they had not undertaken any training in the MCA or DoLs and would have to 'read up' on this and contact the person's social worker and their relatives if people's ability to make decisions changed.

People told us they enjoyed the food at the home. One person told us, "I had, what I call, my favourite last week: bacon, egg, fried tomatoes and potatoes. I love bacon." They went on to tell us they had enjoyed their lunch that day. Another person told us they had ample to eat throughout the day. We saw that staff offered people a choice of what they wanted to eat and their choice was respected. People's nutritional needs had been assessed and staff told us they monitored what people ate and drank on a daily basis and weighed people monthly. If they found people had lost weight or were not eating or drinking enough they would contact the GP. They would also and put in place food and fluid charts to monitor people's intake more closely.

People told us that staff monitored their health needs and arranged healthcare appointments as necessary. One person told us they remained in 'good health' and that the district nurses came in to see them periodically. We looked at people's care records and saw that people were seen by healthcare professionals, such as, the GP, district nurses and opticians as required.

Good

Is the service caring?

Our findings

People we spoke with said they were happy living at the home and enjoyed good working relationships with staff. One person told us, "I get on with the staff very well. They are very, very good." Another person said, "They (staff) are very good." They went on to say that one of the staff members brought in newspapers and magazines which they appreciated. Staff spoke with and about people in a warm and caring manner. We saw that a staff member had brought in some of their home-grown grapes which people enjoyed eating. Another staff member told us they sometimes brought their children to visit when they were not working as the people liked to see them. They said, "It's always like a family here."

People told us they were involved in decisions about their care. They could choose what time they got up and went to bed. They were also able to choose how they spent their time. This was confirmed by staff we spoke with. One staff member said, "We give them (people) choice about what they want to wear and when they want to do something. We don't force them to do anything." They went on to say if they had difficulty communicating with people verbally they showed them options and got the person to point at the preferred choice. Throughout our visit we saw that staff used effective communication and offered people choice.

Staff helped people to maintain their independence. One person explained that they liked to remain as independent as possible. They told us, "I'd rather keep doing things as long as I can. It's better for me to do it." They went on to explain that staff respected their wishes but were available should they require any help.

Staff treated people with dignity and respect. One person told us, "They (staff) are excellent. I don't know where they get their patience from." Staff explained they ensured people's dignity by supporting them discreetly with their personal care needs. They ensured doors were kept shut and that people were covered up as much as possible when they helped them with their personal care. If a GP came in, they took the person to their room to ensure their privacy.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with felt staff knew them, their needs and preferences well. All the staff had worked at the home for many years. Staff told us they could refer to people's care plans for details about their needs but knew the people who currently lived at the home very well. They had staff handovers each day where they updated each other about any changes in people's needs. We saw that the deputy head of care reviewed people's care plans on a monthly basis. They told us they involved people in this process. Whilst people confirmed they were asked if they were happy with their care we found their views were not recorded.

At our last inspection, we recommended that the provider sought advice about person-centred care planning to improve the quality of people's care plans. At this inspection, we found that the provider had not done this and that while care plans were factual, they did not record people's wishes and preferences or evidence people's participation. The deputy head of care told us they did not know where they could access support with person-centred care planning and therefore this had not been implemented.

Staff told us that they recognised people as individuals and valued difference. One staff member told us they made sure that all people's needs were catered for and that people did not face any prejudice. Another staff member said, "I ensure they [people] are heard and are not classed as a number. I don't tell them what they are going to do; it's all about what they want."

People told us they were able to spend their time as they wished. One person told us, "I keep myself busy with my crosswords." They went on to say they went down to the lounge each morning and usually stayed there until after lunch. They then returned to their room where they often watched the television. They went on to discuss current affairs they had heard on the news. Another person told us their eyesight limited their ability to join in with activities but they liked to chat with staff and enjoyed it when their relatives visited.

One staff member told us that people did not always want to partake in activities and preferred to talk with staff. They said, "I always make the time to sit and talk with people." They went to say that both people who lived at the home liked to have a sleep in the afternoon. They explained they left the domestic jobs until people were having their rest. Another staff member told us the people took priority over their domestic tasks. They liked to spend time supporting people to do things they enjoyed doing. The provider said they would like to take people out or have entertainers in but that the people living there had declined both.

People told us they had not had cause to complain but would feel happy to raise any concerns with staff or management. One person said, "They (staff) always ask if everything is alright. I would soon tell them is it wasn't." Staff told us they would take action to address any concerns as they arose and would report these to the provider. The provider told us that they had not received any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last three inspections on 17 December 2015, 10 and 16 November 2016 and 5 and 6 June 2017, the provider had been rated as requires improvement. At our last inspection in June 2017, we found that the provider lacked effective governance systems to identify and drive improvements in the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan detailing how these would be achieved. Despite several contacts with the provider requesting their action plan we did not receive it prior to this inspection.

At this inspection, we found that the provider had not made all the required improvements and remained in breach of the regulations.

The provider did not have effective governance systems in place to assess, monitor and drive improvements in the service. In previous action plans the provider had completed, they told us they were going to introduce and complete checks to monitor the quality of the service. At this inspection they were not able to show us any checks they completed. They were also unable to demonstrate that they had taken any action to make the required improvements identified at our last inspection. For example, at our last we had recommended that the provider sought advice about person-centred care. We found that they had not taken our advice and there was still room for improvement in information recorded in people's care plans.

The provider did not have effective systems in place to learn from and reduce risks following accidents. They had not reviewed a person's risk assessment following a fall to demonstrate how they would reduce the risk of this happening again.

The provider did not have effective systems in place to identify and monitor staff training needs. They did not have an overview of the training staff had completed or when refresher training was required. They did not ensure that they and their staff were suitably trained and competent in their roles. As a result staff were undertaking tasks that they had not received appropriate training for, such as administration of medicines and food preparation. This meant people were at risk of receiving inappropriate support.

There were low occupancy levels at the home and the provider was considering extending their service user band to include people living with dementia to make the business more viable. We were not confident the staffing arrangements in place would support changes in people's needs or the needs of new people who may wish to live at the home.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had not conspicuously displayed their rating from their previous inspection completed on June 5 and 6 2017at the home.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sought people's and staff's views on the quality of the service and any ideas for improvement. One staff member confirmed the provider did ask them their views on how they could "move things forward" but went on to say that they were not sure if these were always acted upon.

People and staff told us they found the provider approachable and they could talk with them whenever they needed to.

The provider told us their aim for the service was to ensure people were warm, happy and content. This was a vision shared by staff who wanted people to have good care in a homely environment. People we spoke with were happy living at the home. Links with the local community were limited at the time of the inspection as the clergy person who had been attending the home had been unwell.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not ensure the ratings from their latest inspection were conspicuously displayed at the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that they and their staff had the necessary training and knowledge required for their respective roles and responsibilities.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to identify and drive improvements in the service. The provider took inappropriate action by giving the remaining two service users who lived at the home just 24 – 48 hours' notice of home closure.

The enforcement action we took:

We issued an urgent notice of decision on the providers registration. The registered provider must not admit any service users to the location Ashgrove Care Home without the prior written agreement of the Care Quality Commission. This includes service users who require to use the service for respite care. The term "admit" includes re-admission of any service user.