Jencare Homes Limited

Asmall Hall Care Home

Inspection report

Asmall Lane
Scarisbrick
Ormskirk L40 8JL
Tel: 01695 579548
Website: www.asmallhallcarehome.co.uk

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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

Overall summary

Asmall Hall is a 17th century manor house, situated in five acres of grounds within a rural green belt area on the outskirts of Ormskirk. Accommodation is provided for up to 56 people, who require help with personal or nursing care needs. There is also a small unit for people who are living with dementia. The home has a minibus and trips out are arranged to local places of interest. Asmall Hall is not on a bus route, but Southport and Ormskirk are only a short drive away.

We last inspected this location on 22nd January 2014, when we found the service to be none compliant with three of the outcome areas we assessed at that time. We found the recording of people's needs and the planning of their care could have been better. The environment was in need of some improvements and the monitoring of the quality of service provided could have been managed in a more thorough way. We asked the provider to submit an action plan telling us how and when they would be compliant.

This unannounced inspection was conducted on 25th March 2015. During this inspection we checked if action had been taken to address the outstanding breach of

Summary of findings

regulations from the previous inspection. We found that whilst some improvements had been made, not all actions identified on the action plan submitted by the provider had been completed.

The deputy manager was on duty on our arrival at the home. We were joined shortly afterwards by the registered manager of Asmall Hall. 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.

Records showed new employees were guided through an induction programme and were supported to gain confidence and the ability to deliver the care people needed. We found the planning of people's care and support to be adequate, although some areas could have been more person centred. We highlighted one particular area around the timeliness of answering people's call bells. We have made a recommendation about this.

The provision of activities could have been better. Although a programme of activities was in place and some people had gone out on a trip to a local market, the people who remained at the home were not engaged in meaningful activities throughout the day.

Medications were not being well managed and our findings demonstrated that proper steps had not been taken to ensure people who used the service were protected against the risks of receiving inappropriate or unsafe care or treatment, in relation to the management of medications. This did not help to ensure people's health; safety and welfare were consistently promoted.

The staff team were confident in reporting any concerns about a person's safety and were competent to deliver the care and support needed by those who lived at Asmall Hall. However, areas of risk had not always been managed appropriately and legal requirements had not always been followed in relation to Deprivation of Liberty Safeguards.

Recruitment procedures adopted by the home were robust. This helped to ensure that only suitable people were appointed to work with this vulnerable client group.

The cleanliness of the premises could have been better. Infection control protocols were not being followed in day-to-day practice. Most areas were in need of upgrading and modernising. The dementia care unit needed to be brought up to date in accordance with specific guidance around environments for people who live with dementia. Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use.

The staff team were provided with a wide range of learning modules. This helped to ensure those who worked at Asmall Hall were trained to meet people's health and social care needs. Regular supervision and annual appraisals for staff were conducted. Staff were kind and caring towards those they supported and anticipated people's needs well. People were helped to maintain their independence with their privacy being respected at all times.

People who lived at Asmall Hall and the staff team were complimentary about the management of the home and felt that if there were any concerns these would be dealt with quickly.

We found several breaches of the Health and Social Care Act (2008) Regulated Activities Regulations. These related to care and welfare, assessing and monitoring the quality of service provided, safety, availability and suitability of equipment, safety and suitability of premises, management of medicines and cleanliness and infection control, which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for Safe care and treatment, good governance, person centred care, safeguarding service users from abuse and improper treatment and safety and suitability of premises.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 

This service was not consistently safe.

People who lived at Asmall Hall told us they felt safe being there. Records showed that any confrontations between people were well managed in order to diffuse volatile situations.

Risk assessments had been conducted, but these were not always person centred and were not consistently reflected within the plan of care.

At the time of this inspection there were sufficient staff deployed to meet the needs of those who lived at Asmall Hall. Recruitment practices were thorough enough to ensure only suitable staff were appointed to work with this vulnerable client group.

Staff were confident in responding appropriately to any concerns or allegations of abuse. People who lived at the home were protected by the emergency plans implemented at Asmall Hall.

Medicines were not well managed and therefore people could be at risk of unsafe medication practices.

Infection control protocols were not always being followed. Therefore, a safe environment was not consistently provided for those who lived at Asmall Hall.

Is the service effective?

Requires improvement 

This service was not consistently effective.

We noted people were free to move around the home, as they pleased, without any undue restrictions being placed on their liberty.

New staff completed a detailed induction programme when they started to work at the home, followed by a range of mandatory training modules. Regular supervision and annual appraisals were conducted.

People's rights were not always protected, in accordance with the Mental Capacity Act 2005. People were at risk of being deprived of their liberty because legal requirements and best practice guidelines were not always followed.

Staff communicated well with those who lived at Asmall Hall and consent had been obtained in relation to various areas of care and treatment.

Some areas of the home were not of suitable design or layout for those who lived at Asmall Hall and adequate maintenance was not in place.

People were not routinely offered a choice of meals, but alternatives were available, should people not like the meal being served. The dining experience was suitable for people who resided at Asmall Hall.

Summary of findings

Is the service caring?

Requires improvement

This service was not consistently caring.

Staff interacted well with those who lived at the home. People were provided with the same opportunities, irrespective of age or disability. Their privacy was consistently respected.

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

People were treated in a respectful way. They were supported to remain as independent as possible and to maintain a good quality of life. Staff communicated well with those they supported and were mindful of their needs.

Is the service responsive?

Requires improvement

This service was not consistently responsive.

The care files we saw were not well organised, which made information difficult to find.

An assessment of needs was conducted before a placement was arranged.

Care plans were found to be completed, but these could have been more person centred in some instances. Sections within the plans of care included information about how people wished to be supported and what they liked or disliked.

People we spoke with told us they would know how to make a complaint should they need to do so and staff were confident in knowing how to deal with any concerns raised.

Is the service well-led?

Requires improvement

This service was not consistently well-led.

Records showed that annual surveys were conducted for those who lived at the home and their relatives.

Records showed that meetings were held for those who lived at the home and their relatives, as well as for the staff team and the managers.

Systems for assessing and monitoring the quality of service provided were not effective.

Evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community professionals.

Asmall Hall Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on 25th March 2015 by two Adult Social Care inspectors from the Care Quality Commission, who were accompanied by a specialist dementia care advisor and an Expert by Experience. An Expert by Experience is a person who has experience of the type of service being inspected. Their role is to find out what it is like to use the service. This was achieved through discussions with those who lived at Asmall Hall, their relatives and staff members, as well as observation of the day-to-day activity.

At the time of our inspection of this location there were 44 people who lived at Asmall Hall. We were able to speak with eleven of them and three family members. We also spoke with ten staff members and the registered manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of seven people who used the service and the personnel records of three staff members. We 'pathway tracked' the care of four people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, training records, medication records and quality monitoring systems.

The provider sent us 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.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection and we asked local commissioners for their views about the service provided. We also requested feedback from 20 community professionals, such as medical practitioners, community nurses, mental health teams and a dentist. We received four responses. In general, their comments were positive.

Requires improvement

Is the service safe?

Our findings

Risk assessments were evident in all of the care files we looked at and although the level of risk was sometimes identified they were not always fully completed. These included risk of falls, pressure ulcers, malnutrition and choking. A form was used when bedrails were put in place but it did not clearly assess the risks. Many of these had been signed by people themselves or their relatives, but it was unclear if the risks of using bedrails had been discussed with them. Plans of care did not follow on from a risk management framework. Therefore, potential risks were not always incorporated in to the care planning process and clear strategies of action were not always evident to reduce the possibility of harm.

An assessment for malnutrition had been completed and reviewed monthly for one person, but this did not conclude with any indicator of risk and was not linked with an appropriate care plan. Staff told us that one plan of care for the same person was no longer valid, as their medical condition had resolved. However, this information had not been used to update the care plan. An assessment of one person's risk of choking had been made in January 2014 by a speech and language therapist (SALT). This had resulted in guidance that food and fluids should be of 'a moist pureed consistency'. We did not see that a care plan incorporated this information.

We found that the registered person had not protected people against the risk of harm, because potential health care risks had not always been appropriately managed. This was in breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our tour of the premises we identified areas of the home, which needed to be made safer. For example, we noted some toiletries and creams belonging to individual people were easily accessible by others, as they were left on open shelving within bathrooms. The handyman's tool store was unlocked, as was the door to the sluice room. This did not consistently protect people from harm.

We saw one person being transferred into the passenger lift in a wheelchair and it was evident that the wheelchair would not fit in the lift with the footrests still in place. Therefore, the staff members who were transporting this individual had to remove the foot rests before manoeuvring the wheelchair into the lift. This was not an ideal situation for the wheelchair user or the staff transporting her.

We noted the doors leading to two flights of stairs from the first level were unlocked and a child gate had been installed to the top of one staircase, in order to promote the safety of those who could not manage the stairs. However, we noted this gate was wide open during our tour of the premises. This area needs to be fully assessed, as a child gate could also create a potential risk, with the possibility of people falling over the top.

We observed an unlocked door at the foot of one staircase. This was not constantly visible and was leading to the rear of the building and a car park and was regularly used by staff members. People would be easily able to exit the building via this route without being noticed. Similarly anyone could gain access through this door and proceed to the first floor bedrooms undetected.

We noted a slight ramp in the ground floor corridor to assist wheelchair users. However, it would be useful if a warning notice was displayed, so that mobile people were alerted to the change in floor level.

We observed several other safety concerns during our tour of the building. These were immediately reported to the registered manager, who assured us that she would address the issues without delay.

We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. This was in breach of regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An infection control policy was in place and we noted that clinical waste was being disposed of in accordance with current legislation and local good practice guidelines. However, windows in some toilets did not open. A curtain screening in the communal down stairs toilet was dirty and stained. None of the bins used for disposal of paper towels or waste were foot operated. We noted that soap and hand gel dispensers were liberally distributed around the home.

Requires improvement

Is the service safe?

However, many of these were found to be empty and therefore people had limited access to hand washing facilities. Although, in general the home throughout was pleasant smelling, one bedroom we visited was very malodorous. A bathroom on the first floor needed a thorough clean. Corridor carpets were threadbare in places and in need of a thorough clean, as were the carpets in some of the bedrooms we visited. One member of staff said, "It's not as clean as it could be."

The flooring in one of the bathrooms on the first floor was splitting and if left unrepaired could potentially create a trip hazard for those who used this facility. This also provided an ideal site for the growth of bacteria. We noted that when one person was served lunch on his over-bed table in his bedroom there was a half full urine bottle on his bedside cabinet. All staff we spoke with said that while three people had specialised hoist slings in their bedrooms, dedicated for their use only, others who needed hoisting shared slings. No-one knew of a cleaning schedule for the slings, in order to promote infection control. Staff told us they were washed if visibly contaminated, which did not help to reduce the possibility of cross infection. This did not promote good infection control practices.

We found that the registered person had not protected people against the possibility of acquiring an infection because effective systems were not in place to promote good infection control practices. This was in breach of regulation 12(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication policies and procedures were in place at the home. A recent medication audit had been conducted by the supplying pharmacist, which raised some concerns. Therefore, he had organised medication training for relevant staff, which would be held within the next few weeks.

Medicines received into the home were recorded appropriately and were stored safely. Controlled drugs were well managed and nursing staff followed safe practices when disposing of these medications. Although, the drugs fridge temperatures were monitored on a daily basis, action had not been taken when temperatures were outside normal limits for the preservation of medications.

We looked at ten MARs (Medication Administration Records), which all had photographic identification, with any allergies being noted. We observed medications being administered on both units and found people received them on time and in a safe manner. Clear communication was maintained throughout.

Staff giving out medicines were seen to ask people if they required any analgesic for pain relief or aperient to relieve constipation. However, there were no written indicators in use for individual's specific health care needs. This was particularly important for people who lived with dementia, where they may lose the ability to communicate verbally, over time and therefore staff will need to know how they express pain and where their pain is.

All staff we spoke with, who administered medicines said that 'as and when required' medicines should be counted and recorded on the MAR charts at least once a week. They told us this did not often happen and records we saw confirmed this. We selected medication counts at random and found that for one person, there were 17 'as and when required' tablets more than there should have been, according to this person's MAR chart. This showed the records were inaccurate and indicated tablets had been signed as being given, when they had not been administered. This was concerning as, in this case pain management may have not been effective.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with who lived at the home told us that, in general they felt safe living at Asmall Hall. One person said, "I just feel safe. I have a special wide bed and a pulley over my bed, so I am safe pulling myself up. I do feel a bit cut off though, because I am too far away from what is going on. But yes I feel safe enough." Another commented, "Yes I do feel safe, but I can't lock my door so I feel a bit vulnerable." A relative said, "I come in every day. I know she is safe. I would like to lift her out of her chair, but the carers won't let

Requires improvement

Is the service safe?

me. They say it's safer if they do it." None of the people we spoke with or their relatives had ever witnessed any bullying or abuse. One person said. "All the staff are very patient. 10 out of 10."

We observed people were free to move around the home, as they wished and those able to communicate reported feeling happy and in good spirits. Care records we examined documented incidents where confrontations had occurred between people who lived at the home and it appeared that appropriate and safe techniques had been applied by staff to diffuse issues satisfactorily.

Detailed policies and procedures were in place in relation to safeguarding vulnerable adults and whistle-blowing. Records showed staff had completed training in this area. A system was in place for recording and monitoring any safeguarding referrals, so that the manager could easily identify any themes or recurring patterns.

Staff we spoke with were easily able to discuss safeguarding policies and were aware of whistleblowing procedures. They all knew what constituted abuse and what action they needed to take, should they be concerned about the safety of someone in their care.

Relatives we spoke with thought there were enough staff on duty. One said, "When we are in the lounge you press the bell once for attention and twice in an emergency and they (the staff) all come running." One person who lived at the home told us, "The night medication comes late. It can come between 10pm and 12mn. They (the staff) have to wake me and then I take a long time to get back off to sleep again." Evidence was available to demonstrate that the turn-over of staff was very low and records showed no agency staff had been utilised at weekends for the previous two weeks.

Staff members we spoke with told us there were enough staff on each shift to meet the needs of people who lived at the home. They said they were well supported by managers if they needed more staff to cope with unexpected increases in dependency. We were told staff holidays and sick leave were covered by existing staff or bank staff, who knew people well. They confirmed that 'hands on' support was provided by the managers, when needed or occasionally agency staff were utilised. However, they all said that agency use had declined significantly in recent months and that it was now rare to use agency workers.

During our inspection we looked at the personnel records of three members of staff. We found recruitment practices adopted by the home to be robust. Prospective employees had completed application forms, including health questionnaires and any gaps in employment had been further explored. Applicants had produced acceptable identification documents, with a photograph. All necessary checks had been conducted before people started to work at the home. These included two written references and a police check. Staff spoke with talked us through their recruitment and told us this was thorough.

Accident records were appropriately recorded and these were kept in line with data protection guidelines. This helped to ensure people's personal details were maintained in a confidential manner. Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations, so that they were fit for use and protected people from harm.

Most staff we spoke with said there were not enough hoists in the home to meet the needs of people who lived there. We were told there were two hoists in the building, although one member of staff thought there were three. One person who lived at the home told us, "One of the main problems is they only have one stand hoist and one proper hoist, so you have to wait for them to become free. Two of each hoist on each floor would be better." The hoists we saw had been serviced within the last year to ensure they were safe for use. The deputy manager subsequently told us there were 4 mobile hoists within the building and 17 people who required a hoist for transferring.

We would recommend that the registered manager assesses if the number and type of hoists available are sufficient to meet people's needs.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 22nd January 2014 we found some work was needed to make improvements to the environment. The provider submitted an action plan, as requested. We checked what action had been completed in order to enhance the premises, in accordance with information sent to us by the provider. At this inspection we found that although some improvements had been made, further developments were still needed.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms. We found some rooms had damp patches on the walls and ceilings. The linings of the curtains hung in one bedroom were torn and in need of replacement. A lot of the furniture was old and did not enhance the environment for those who lived at Asmall Hall.

Some floor coverings had been replaced since our last inspection, but others were in poor condition and in need of replacement. Signage for the dementia care unit we were told had been sourced and installed. However, this was not prominent for those who lived with dementia.

The action plan indicted that the maintenance and development plan would be updated by May 2014. We requested this at the time of our inspection and subsequently by email. However, it had not been produced at the time of writing this report four weeks after the inspection date. The deputy manager confirmed that surveys for people who lived at the home had not been conducted in accordance with the action plan submitted, but these would be circulated during May 2015.

The above continued breaches surmounted to a breach of regulation 17(2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home dated back to the 17th century. A beautifully maintained enclosed garden was easily accessible for people who lived on the dementia care unit. We noted some slight malodours within this unit, but efforts were being made to tackle this problem. The unit was not particularly well designed to meet the needs of people who lived with dementia or who were experiencing mental health issues. We did not see evidence of dementia friendly resources or adaptations in the communal areas corridors or bedrooms of the dementia care unit. People had little chance to explore their surroundings. The lack of dementia friendly amenities resulted in lost opportunities to stimulate exercise and to relieve boredom, as well as enabling people to orientate themselves to their environment.

We found colour schemes did not help with orientation and the lack of prominent picture signage did not easily identify areas, such as bathrooms and toilets. Some small signs, at times conflicted with green fire exit signs, which would make it difficult for people to differentiate. One nurse explained how pictures and signing things could be used to communicate with people living with dementia but that no pictures were available to them. Floor coverings were a mix of highly elaborate patterned carpeting, differing coloured plain carpeting and wood style vinyl flooring. This could be confusing for people who live with dementia.

Pictures, prints and reproduction solid objects seemed to be randomly scattered on walls that appeared at times incongruous and irrelevant. This did not promote a structured environment for people who lived with dementia. A person we walked with pointed to one sign and read out, “Dining Room. One hundred and One.” The One Hundred and One was in fact a graphic design of a fork, plate and knife.

Some bedrooms were dimly lit and in need of decoration. We saw bed side tables were not always provided for people who were sitting in their bedrooms, so they could have easy access to a drink and personal belongings. Some beds were pushed up in front of wardrobes, which restricted access to people’s clothing and in some cases there was little room for relatives to sit when visiting someone in their bedroom. One person told us, “They (visitors) have to sit on my bed. If they sit on the chair they are behind me and I can’t see them.” Some furniture and fittings in bedrooms were old and in poor condition. The bedding we saw, although clean, was washed out, thin and unattractive, as were the towels and face cloths. The home throughout was in need of some upgrading in order to provide a homely environment and pleasant surroundings for the people to live in.

We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout and adequate maintenance was not maintained. This was in breach of regulation 15(1)(a)(c) of

Requires improvement

Is the service effective?

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with and their relatives told us they thought staff were sufficiently trained to meet their needs or the needs of their family members. One relative said, "I watch them (the staff) with my wife and the other residents. They are very competent. It's very reassuring. Some of the staff have worked here a very long time. They are not just kids. They are very experienced."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Policies and procedures were in place in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). These covered areas, such as restrictive practice, capacity and best interests.

Care records we saw reflected a general understanding of the principles and requirements of the MCA and DoLS. Applications to local authorities requesting DoLS approvals were evident, but we saw no evidence of acknowledgement, although many applications were dated as being re-sent on at least one occasion.

We received some verbal feedback from community professionals before our visit to the service. Comments included, "They (the staff) are well aware of DoLS and what should be done, but resources are not always available. They do make applications for people they should, but maybe not everyone."

Staff who worked on the dementia care unit and one member of staff on the general unit had a good understanding of mental capacity to consent and Deprivation of Liberty Safeguards (DoLS). However, one staff member on the general unit was less clear.

We were made aware of a GP agreeing to the covert administration of medications for one person who lived at Asmall Hall. The policies of the home clearly outlined the procedures for covert medications, which were being followed in this case, in relation to mental capacity assessments and best interest decisions, which involved medical practitioners, staff members and family.

The care files we examined all contained a form entitled, 'Consent to lock disclaimer', which had been signed by a relative. The form indicated that each person had agreed that they did not want their bedroom door locked. A range of consent forms had been completed, which covered areas, such as catheterisation, the taking of photographs and monitoring weight. These were signed by the person who received care and support or their relative. However, we were not sure these decisions had been made through a robust decision making process, or if the relative signing the documents had legal rights through a Lasting Power of Attorney arrangement.

At the time of our inspection there was a broad range of staff on duty, with different skills and qualifications, who were seen to be providing effective care and support for those who lived at Asmall Hall. Staff members spoken with told us they received regular training each week, particularly in relation to understanding dementia and conditions specific to the needs of those in their care. We saw a training plan was displayed on a notice board within the home. Staff we spoke with and those we observed, had an in depth knowledge of people and relationships were open and friendly. Staff were able to tell us much of people's likes and dislikes and they knew the people in their care well.

Staff said they had enough training to meet the needs of people living at the home and that additional training needs were discussed at regular supervision meetings. One person had asked to do additional training about catheterisation and venepuncture and it had been planned. Another was being supported to complete degree level training in health care.

Evidence was available to demonstrate that those who worked at Asmall Hall were supported to do the job expected of them. Staff personnel records showed new employees had completed induction programmes. They were also issued with a staff handbook, which contained a wide range of relevant information, such as important policies and procedures. Staff were provided with job

Is the service effective?

descriptions relevant to their specific role and terms and conditions of employment, which outlined what was expected of them whilst working for the company and action which would be taken in the event of staff misconduct, as well as the appeals process.

Records showed that all staff members received a wide range of mandatory training programmes, which included areas, such as fire awareness, moving and handling, medication awareness, food hygiene, emergency first aid, communication, record keeping, safeguarding adults and health and safety. Training had also been provided in relation to conditions specific to the needs of those who lived at Asmall Hall. We spoke with three members of staff who were all undergoing, or had just completed further training in areas such as, infection control, moving and handling and food hygiene. Staff spoken with told us that training was regular and it was valued by the staff team. Records showed that a good percentage of staff had achieved a nationally recognised qualification in care. This helped to ensure the staff team were well trained.

Supervision records were seen in staff files and annual appraisals were available for us to examine. These allowed employees to discuss their work performance and training needs with their line managers at structured and regular intervals.

The care files we saw showed the involvement of a wide range of external professionals, such as Speech and Language Therapists, community nurses, psychiatrists, GPs, dentists, opticians, and psychologists. This helped to ensure people's health care needs were being appropriately met.

People's dietary preferences were documented within individual plans of care. We spoke with staff about the management of meals. Meal times were important periods of the day when routines needed to be maintained and this was observed during our inspection. Communication between staff members and those who lived at the home was good. Staff spoken with were fully aware of people's preferences, including their dietary likes and dislikes.

We observed lunch being served on the Mulberry Unit. We noted there were a sufficient number of staff on duty in the dining areas to ensure everyone received their meals in a timely fashion. Some people were being supported to eat their food independently, whilst others were assisted with their meals in a gentle and dignified manner.

The food served looked appetising, but there appeared to be only one choice available for the main course. However, we did observe one person express their dislike for what was on offer and so this individual was provided with a plate of sandwiches, as an alternative. We noted that one person was served a main course without the vegetables, because he did not like vegetables and this was clearly recorded in his plan of care. It was evident that there was far greater variety offered for the dessert menu.

Hot and cold beverages were constantly available throughout the day. Tea, coffee and fruit juice was available at lunch time. We observed staff making every effort to ensure people had sufficient fluid intake. However, one person told us, "I have asked for a cup of tea when I wake up in the morning, but I get told to wait till I get my breakfast." People told us drinks of their choice were offered at night time, but they did not get offered any supper.

People we spoke with thought the food was, in general satisfactory. Comments included, "It's nothing to shout about or write home about." "The food is reasonably good, but we could do with more fresh fruit."

We did not see the menu displayed in the home, to allow people to browse the meals on offer. We asked the registered manager if a menu was ever displayed in the home and she said, "No, the menu is on the wall in the kitchen. We do not put one up in the dining room or on the tables. A carer reads out to the residents what is on offer each day and they choose what they want to eat." Although people could select from the menu read out to them, there was no opportunity to browse the menu themselves before selecting their food. This method of ordering food did not allow more able people the opportunity to make informed choices.

We observed a care worker speaking very kindly to one person they were supporting with their lunch. The member of staff encouraged this individual in an unhurried and relaxed manner.

Sixteen people took lunch in the main dining room on the general unit. Two other people choose to eat in a separate dining room. The tables were nicely set with appropriate knives and forks for different abilities. Fresh flowers taken from the garden adorned the tables. We saw specialised

Requires improvement

Is the service effective?

utensils and crockery were provided to promote independent eating. We observed that residents could take their meals in the lounges or their private accommodation, as well as the dining room.

The lunch time meal was home cooked and looked appetising. However, those who needed soft or pureed diets, because of swallowing difficulties were served their food in a bowl, rather than on a plate, where the separate tastes could have been presented in individual moulds. We heard staff members offering assistance, such as cutting the food up for people, if they so wished and we observed people eating at their own pace, without being rushed.

We spoke with the Environmental Health Officer prior to our visit to Asmall Hall. A food hygiene inspection had recently been conducted, when the service was awarded a level 5 rating, which is the highest level available.

Requires improvement

Is the service caring?

Our findings

People we spoke with said they were very well cared for at Asmall Hall. Comments included, "All the staff are lovely we are looked after very well." "They all know my name they help me. They close my curtains when they are helping me to dress. I just wish they had more time to just sit and talk to me. I get very worried about my condition." "Yes they are all lovely, what I see of them."

Comments from visitors included, "The staff are very welcoming and we are always offered a drink and a biscuit." "They give full attention to the residents. They look out for us as well as the residents. They always ask how I am when I arrive." "I am glad she (relative) is here I wish she was at home, but this is the next best thing."

One relative told us that the care his wife received was very good. However, he also reported two occasions where he felt his wife's care was found to be lacking, but his overall impression was positive. None of those who lived at the home or their relatives had any concerns about the approach of any of the staff team.

We spoke with two family members, whose relative had very recently passed away at the home. They described the staff as 'very caring' and 'kind', particularly when delivering end of life care. They told us that the staff team looked after the family as well as their relative. One of them said, "He was kept so comfortable and clean right up to the end."

Support plans outlined the importance of promoting people's privacy and dignity and promoting their independence. Staff spoken with were fully aware of the need to respect those in their care.

We found a sense of calm throughout the home, where we saw respectful, kind and patient care being afforded to those who lived at Asmall Hall. People were well presented and looked comfortable in the presence of staff members.

Interactions we observed between staff members and those who lived at the home were all pleasant, polite, friendly and unhurried. Staff expressed their genuine concern about individual people when talking with us.

One member of staff said they worked at the home because, "I enjoy it; I've done other things but came back to caring for people." Another said, "I like being a nurse. I like caring for older people." One member of staff had received end of life training in a previous employment. Another said they had not had this type of training, but was aware about people's records containing information about 'thinking ahead.'

All staff we spoke with said they had ample time to sit and talk with people who lived at the home and were able to tell us details about individuals. This included something about their lives and their families. Staff members were able to discuss the risks people encountered, as well as steps implemented to reduce the possibility of harm.

We saw staff approach those who lived at Asmall Hall in a way which was most suitable for each individual and it was clear that people were provided with the same opportunities, irrespective of their disabilities. This was supported by the equality and diversity policies and procedures of the home. We saw two members of staff attend to one person, who was bedfast. They supported the individual in the most gentle, caring and appropriate manner. They told us about instructions contained in this person's care plan and they were following these in day-to-day practice.

All those we spoke with and their relatives told us they did not have any involvement in the care planning process. We were told by people we spoke with that staff did not sit down with them and discuss what was important to them or how they wished their care to be delivered. One person said, "Staff never have time to stay for a chat. The only time they chat is when they come to do something for me." However, we noted those who used the service or their relative had signed the plans of care, which indicated they were satisfied with the contents.

One person told us he was very worried about a medical problem he had. He showed us a letter he had received from a recent consultation with his specialist at the hospital. He said, "I need someone to explain why I am not getting any better." He added, "I can't be bothered any more I can't even be bothered to have a bath or a shower. I just have a strip wash every day. No-one seems to want to help me. I am all alone since my sister died and I have no family left."

Another person told us that he had never been asked if he was happy with the care provided. He added, "I would like to be able to read a book, but I lie down all the time. I could do with a rest for the book so I could read sometimes."

Requires improvement

Is the service caring?

During discussion with the management team about activities people in wheelchairs were referred to as 'pushers'. This is inappropriate language, because it 'labels' a particular group of people and does not promote dignity and respect.

Whilst most feedback we got was positive we did also observe and hear about the experiences of people waiting a long time for assistance. For example, we visited one person in his room. He asked us to assist him with a task, which was outside our remit. Therefore, we suggested he press his buzzer and get a carer to help him. This he did. We waited a good ten minutes for a carer to arrive, only to be told that she would have to get someone else to assist her, due to the layout of this bedroom (the bed was double size and was pushed up against the wall, because the room was small). We waited another twenty minutes for the care worker to return. She then summoned a passing colleague to assist her with this individual. We were told that the reason for our long wait was that other carers were busy supporting other people. At the time of this event there were 12 staff on duty, including the registered manager and deputy manager. We discussed this with the management team, who told us the delay in answering the call bell was because there had been a medical emergency, where all staff had attended. Therefore, we were provided with conflicting information.

One person, who lived at Asmall Hall told us, "It's always five or ten minutes wait when I press the bell. We get a lot of agency staff at the weekends. You never know who is looking after you. If I ring and a carer comes and I want to see a nurse I have to wait again till the nurse comes." Another said, "Sometimes they are short staffed especially at weekends, it's bad then. Sometimes I can wait for a very long time and sometimes no one comes. I suppose they come when they can." We recommend the manager review arrangements for the effective deployment of staff to ensure people receive assistance in a timely manner.

We would recommend that the provider ensures staff understand that the time in which people's call bells and requests for assistance are answered is important to the quality of life for people who live at the home.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on 22nd January 2014 we found assessments of people's needs had not always been conducted and care had not consistently been panned in the best way for those who lived at the home. The provider submitted an action plan, as requested. We checked what action had been completed to improve the service, in accordance with information sent to us by the provider. At this inspection we found that although needs assessments had been conducted, on occasions these had not been completed and some plans of care were not sufficiently detailed.

The plans of care we saw varied in quality. Some were tailored to those who lived at the home. For example, the records of one person showed he enjoyed reading the Daily Mail and we were able to observe the latest copy of the newspaper available in his room. The plan of care for another individual was particularly person centred in relation to personal care needs and preferences. However, in some cases information was not always as detailed as it could have been. For example, in one care file the section headed, 'sleeping and bed time' had no detail in respect of this person's preferred bed time and usual rising time and in some care files we saw there was no detail recorded in relation to food and mealtimes. Some plans of care had been reviewed regularly and any changes in people's needs had been recorded well. However, some had not been reviewed for some time and others did not provide clear guidance which would enable staff to deliver the care and support that met people's individual needs and preferences.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because the care planning process was not always sufficiently person centred and potential risks had not always been managed well. This was in breach of regulation 9(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members we spoke with were fully aware of what people needed and were able to discuss individual needs and preferences. This showed they knew people in their care very well. However, the plans of care did not always accurately reflect what staff members had told us. From discussions with staff it was evident they provided a lot more care and support for people than was actually recorded within the plans of care.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because plans of care failed to accurately reflect people's assessed needs and the reviewing process was not always regular. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care files of eleven people who lived at the home. We found information was often duplicated on different forms. The care records were large and cumbersome, containing much information which was out of date and which could have been archived. They were not well organised, which made information sometimes difficult to find.

Records showed that assessments of people's needs had been conducted before a placement at the home was arranged. We noted that in most cases efforts had been made to gather details about people's wishes and preferences. This helped to promote personalised care and aided the staff team to be confident in delivering the care and support people needed. A snap shot of people's life history was at the front of their care records and throughout the documentation we found references to how people wished to be supported and their individual likes and dislikes, as well as other things that were important to the individual.

We noted some good responsive actions had been undertaken in relation to the management of medications. For example, when a person had refused medication on consecutive days, despite efforts to persuade them by staff, a community psychiatric nurse had been contacted and asked to review the person. Another person had been prescribed antibiotics twice daily of a type which are usually given three times a day. A nurse had noticed this and contacted the prescribing doctor's practise nurse to confirm the dose and time was correct.

Requires improvement

Is the service responsive?

The use of behaviour management records were found to be substantial, evidencing that distressed reactions were monitored, understood and action plans were created to prevent situations, which may result in people experiencing negative wellbeing.

Two activity coordinators were employed at Asmall Hall. We noted a variety of activities were provided, which included weekly trips out in the home's mini bus to local places of interest. However, we noted that there could have been more low level activities provided throughout the day within the Mulberry Unit, such as newspaper discussions, review of the day and weather, quizzes, music groups and low level physical activity.

We sat in one of the communal areas for a long period of time. We observed between seven and ten people sitting in this room for an hour and a half. The television was on continually. Two people appeared to be watching the television for approximately 35 minutes. One person continued watching for another half hour. Two people were asleep during the whole period. Another person went to sleep later. One person had visitors during that time. Although a member of staff sat at a desk in this communal lounge and others came in and went out, none of them attempted to engage people in any activities during the period of time we were present.

The notice board displayed, a sign stating, 'What's happening in the month of March?" Where a variety of activities were highlighted, such as a church service, a trip to Southport, a tea dance at the civic hall, an Irish pub quiz, visiting entertainers to celebrate St Patricks Day and morning coffee at the Marina. On the day of our inspection four people went on a shopping trip into Ormskirk town centre. However, it was evident that no form of activities were provided for those who remained at the home during this time. People who were less able or confined to their beds did not get the opportunity to join in any of the above mentioned activities and the programme for the month of March did not incorporate pastimes for those who had more complex needs. People we spoke with were unable to recall any recent activities that occurred on a daily basis.

We viewed a number of bedrooms during our inspection. Some we found to be very personalised with objects and pictures displayed that were clearly personal and important to those who lived in these rooms. This promoted individuality and maintained people's interests. Others we found to lack personalisation, as the walls were bare and the rooms void of any personal items. Each had a 'Memory Box' outside the bedroom door. The use of these boxes varied greatly, some holding personal photographs, memorabilia and a brief resume of people's likes and dislikes. However, others were left completely empty.

A complaints policy was in place at the home and a system was in place for recording and monitoring complaints. Each step of the process was clear, which enabled a distinct audit trail to be followed. A relative we spoke with told us she would not hesitate to contact the registered manager if she had any concerns and she felt issues would be dealt with appropriately. All the people we spoke with said they knew the manager. Everyone said they had no complaints, but if they had they would be happy to tell the staff.

Requires improvement

Is the service well-led?

Our findings

At our last inspection on 22nd January 2014 we found the registered person had not implemented robust systems to regularly assess and monitor the quality of service provided. The provider submitted an action plan, as requested. We checked what action had been completed to improve the service, in accordance with information sent to us by the provider. We found that although some risk assessments had been implemented since our last inspection, these were not always sufficiently detailed in order to protect people from harm. Also the registered provider had not regularly sought the views of those who used the service, or those acting on their behalf, to enable constructive feedback to be obtained, so that any shortfalls identified could be appropriately addressed.

The action plan submitted by the provider following the previous inspection stated that feedback would be sought from those who lived at the home and their relatives, in the form of surveys, every six months. The deputy manager told us this had not been implemented at the time of our inspection, but would be started in May 2015.

A range of quality audits were conducted regularly, which included areas such as, improvement programmes, admissions to the home, record keeping, data management, medications and care planning. However, these were not always effective because issues identified at the time of our inspection had not been recognised during the internal auditing process. It was evident that the medication audits had highlighted repeated issues in relation to two nurses checking and signing for medications received into the home. This was discussed with the management team. The deputy manager told us that this was an ongoing issue, despite memos and notices being displayed. An action plan had been developed in response to the medication audits, but this had not been followed up. We did not see audits had been conducted in other domains, such as infection control and the environment. Therefore, shortfalls which needed to be addressed in these areas had not been identified by the internal assessing and monitoring processes. Staff spoken with said they had no involvement in any of the auditing processes, but thought the managers did these.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. This was in breach of regulation 10(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked if action had been taken to address the outstanding breach of regulations from the previous inspection. We found the registered manager had failed in part to ensure all the regulations had been appropriately met.

Not all actions had been taken, in accordance with the provider's action plan submitted following the last inspection. For example, some plans of care did not accurately reflect people's needs and had not been reviewed for some time, although the action plan stated they would be reviewed each month by senior staff.

The provider of this service was also the registered manager, who had been in post for a good number of years. People we spoke with and their relatives were all aware of who the registered manager was and felt they could approach her if they had a problem or concern. We saw the registered manager interact politely with people who lived at the home and they responded to her well.

We found that minutes of meetings were retained and staff confirmed they had meetings periodically, so that they could get together and discuss any relevant topics in an open forum.

Asmall Hall had been accredited with an external quality award. This meant that an outside professional organisation audited the home periodically. A business continuity plan was in place, which covered evacuation procedures due to emergency situations or environmental failures, such as loss of power supplies, flood, severe weather conditions or fire.

Prior to our inspection we examined the information we held about this location, such as notifications, safeguarding referrals and serious injuries. We noted we had been told about things we needed to know in accordance with The Care Quality Commission (Registration) Regulations 2009.

A wide range of written policies and procedures provided staff with clear guidance about current legislation and up to date good practice guidelines. These were reviewed and

Requires improvement

Is the service well-led?

updated regularly and covered areas, such as The Mental Capacity Act, Deprivation of Liberty Safeguards, consent to care, safeguarding adults, infection control and health and safety.

We established that the entire workforce had a genuine desire to provide good care for those who lived at Asmall Hall, with both staff and management promoting a relaxed and enjoyable living and working environment. However, we found many aspects of the management style to be more reactive than pro-active. Staff we spoke with told us they were happy working at Asmall Hall and many had been there for several years.

It was clear from reading care records and from talking with staff that Asmall Hall worked well and regularly in partnership with other professional agencies from a wide spectrum.

Everyone we spoke with felt the home was well-led. One member of staff said, "Yes, the manager is a good manager. We can approach her with any problems and she will sort them out as soon as possible." They all said the manager was visible around the home every day and that either the manager or her deputy were always available, day and night, in case of emergency situations.

One care worker said, "The care here is good because everyone is concerned about the residents and the managers support the staff."

One community professional wrote on the feedback, 'Asmall Hall is always clean and pleasant smelling. I am treated with respect and in a friendly manner by all the staff, including cleaners and the handyman. The residents are always clean, appropriately dressed, appear relaxed and happy and are themselves treated kindly and with respect both when I am there and when I have just walked into a room unexpectedly. I would recommend the home to friends and family.' Another commented, 'I have been involved with Asmall for many years and I have always found that the manager and her deputy have been dedicated to the care of the clients of Asmall. They have always been responsive to any suggestions and advice and are quick to ask for help if they need it. On my visits to the home I have always found that the clients' needs are paramount to the staff and often leads to discussion about what could be done to help people, particularly in regards to those who have difficulty swallowing.' And a third stated, 'They mean well. They're not always as organised as they should be. The management of the home seems erratic and disorganised, but they mean well. The dementia care unit smells.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Proper steps had not always been taken to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment. This was because risks relating to their health had not always been well managed. Regulation 12(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against risks because an effective system was not in place to identify, assess and manage environmental risks relating to the health, welfare and safety of those who lived at the home. **Regulation 17 (1)(2)(a**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service and others were not always protected against the risk of acquiring an infection because infection control protocols were not consistently being followed. Regulation 12(1)(2)(h)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with the unsafe use and management of medicines. This was because appropriate arrangements had not been made for the obtaining, recording, using and safe administration of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not protected people against risks associated with unsuitable premises, because some areas of the home were not of suitable design or layout and adequate maintenance was not maintained. Regulation 15(1)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager had failed to address all breaches of regulations made at the previous inspection. Action had not always been taken in accordance with the action plan submitted by the registered person following the previous inspection. Regulation 17(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

We found that the registered person had not protected people against the risk of unsafe care or treatment, because the care planning process was not always sufficiently person centred and potential health risks had not always been managed well.

Regulation 9(1)(a)(b)