Barchester Healthcare Homes Limited

Ashfields

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection was unannounced and took place on 13 January 2015.

At our last inspection on 08 and 11 July 2014, we asked the provider to make improvements in respect of concerns about the lack of adherence to the Mental Capacity Act (MCA), ensuring that people's needs were met and with the staffing levels provided. An action plan that told us how and by when the necessary improvements would be made was completed by the provider and the anticipated outcomes considered as part of this inspection.

During this inspection we checked on their improvement plan and found that action had been taken about adherence to the MCA and ensuring people's needs were met. However improvement had not been made to staffing levels.

Ashfields provides care and accommodation for up to 44 older people who are living with dementia. On the day of this inspection there were 40 people living at this home.

This service is required to have a registered manager in day to day charge of the home. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

There were discrepencies in the administration of controlled drugs. The quantities of some drugs did not correspond to the amounts recorded in the controlled drugs register. There were gaps in the medication administration records of other medicines administered by staff. You can see what action we have told the provider to take at the back of the full version of this report.

People did not always receive the support and assistance they needed to eat and drink. Some people did not receive assistance in a timely way so that their food or drink had gone cold by the time staff were available to help them. You can see what action we have told the provider to take at the back of the full version of this report.

On the day of our inspection the home was being managed by the deputy manager, who was also providing care support due to staff shortages. During our inspection staff were not organised and did not receive clear direction about the tasks needed to be completed and who was responsible for them. There was a lack of oversight and support from the provider. You can see what action we have told the provider to take at the back of the full version of this report.

Staff knew about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They understood how this legislation affected the way they supported people and acted in the person's best interests.

Care plans provided sufficient information to staff on how to support people. Other records about people's care were not consistently completed. Where necessary, staff involved other professionals in people's care. Staff were alert to changes in people's physical and mental health and referred to other professionals promptly.

People were offered choices and supported to make decisions around daily living. Although staff were hurried, they were always kind, compassionate and caring towards people. Staff worked hard to find time to speak with people and raise a laugh.

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

The service was not consistently safe.

There were not enough staff on duty to provide safe care in a timely manner.

Medicines were not recorded and controlled safely and there were discrepancies between the records and medicines held.

Staff understood about abuse and knew what to do if they suspected abuse was happening.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were suitably trained to fulfil their role. Staff had an understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

People had a choice of meals and drinks but were not always supported effectively and in a timely way to eat and drink.

People's health care needs were met in a timely way. Health professionals visited the service when required.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and caring towards people. They treated people with dignity and respect.

Care and support given to people was person-centred and not task driven.

People were listened to and staff acted in accordance with their wishes wherever possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff understood how people liked to live and how they preferred to be supported.

Some daily records were not completed regularly and were not consistent with our observations of the care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management arrangements at the time of the inspection were not adequate to ensure the smooth running of the home. There was a lack of oversight and support from the provider.

Summary of findings

Audits of the quality of the service were taking place but there were significant gaps. Medicines were not being audited to ensure they were being stored and administered correctly.

The views and opinions of people and their relatives were sought annually and plans developed to improve the service.

Ashfields

Detailed findings

Background to this inspection

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

This inspection took place on 13 January 2015 and was unannounced. This inspection was completed by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed notifications that had been sent to us by the service. These are reports required by law, such as the death of people, safeguarding, accidents or injuries. We also contacted the local authority quality monitoring team to seek their views about the quality of the service provided for people.

During the course of the inspection we gathered information from a variety of sources. For example we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included staff rotas, medication records, Mental Capacity Act and Deprivation of Liberty Safeguard assessments and applications and the care records for eight people

We also spoke with approximately 10 people, spoke with two visitors and spoke with staff on duty including all care staff, chef, deputy manager and administration staff.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection on 08 and 11 July 2014, found that there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the lounge where people with more advanced dementia spent their time was not always staffed, putting people at increased risk. The provider undertook to redeploy staff so that this lounge was always staffed. During this inspection we found that this lounge was not staffed for the majority of the day. People were observed shouting for assistance and getting out of their chairs, putting themselves at risk of falling and requiring the inspector to call for a member of staff for assistance. The number of people using the lounge varied during the day but at one point we saw that there were three people in there and unsupervised.

We looked at the arrangements in respect of storing and administering medicines and found that the register for controlled drugs was not accurate. There were discrepancies in the amount of three controlled medicines. We highlighted this to the deputy manager and they agreed to carry out an investigation. We referred this matter to the safeguarding authority.

The temperatures of the medicines refrigerator and medication room were not being checked and recorded routinely. This meant that we could not be sure that medicines were stored at the correct temperature.

We looked at the Medication Administration Records (MAR) and saw gaps in the administration of oral medicines in two MAR charts. We found significant gaps in all of the topical medicines charts for people who were prescribed creams or ointments. Staff were unable to tell us if these creams had been applied as required. Staff told us that they had either forgotten to sign the charts or did not have time to do so. This meant that we could not be assured that people had their topical medicines applied as prescribed.

These concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010. You can see what action we have told the provider to take at the back of this report.

Appropriate arrangements were in place in relation to obtaining medicine. Medicines were ordered on a monthly basis and the pharmacy dispensed the medicines in sealed, pre-measured doses every month. Medicines were disposed of appropriately by returning unused or surplus medicines to the pharmacy.

People received their medicines on time and staff followed safe administration practice. We saw that the Medication Administration Records (MAR) contained information about people's allergies and swallowing problems.

People who lived in the home were not consistently safe because there were times when there were insufficient numbers of suitable staff available to keep them safe and meet their needs. The deputy manager told us that the provider's required number of care staff were seven in the morning, six in the afternoon and evening and three at night. They told us that an activities co-ordinator worked each day in addition to the care staff.

On the morning of our inspection there were four care staff and two activities co-ordinators on duty. Two care staff had telephoned in sick. The deputy manager was assisting with people's care due to the lack of staff but was also required to deal with the day to day management of the home. Both activities co-ordinators were also assisting with people's personal care needs and this meant that they could not undertake their activities role during this time. Two staff extended their working day to provide additional cover over lunchtime and afternoon.

We observed the impact the shortage of staff had on people's care and support in addition to the risks already described. For example, we noted that a significant number of people were in their rooms either because they were unwell or through choice and staff were rushing from one room to another to support people. We noted that people in their own rooms were not directly observed at regular intervals during the day to make sure they were safe.

We spoke with staff and they told us that they did not feel there were enough of them on duty to safely meet people's needs in a timely way. They felt that people were not being supervised as they should be. They told us that the morning shift on the day of our inspection had been particularly difficult and they had very little time to go back and check on people. Staff said they were short most days.

Requires Improvement

Is the service safe?

After the inspection we spoke with the registered manager about the staffing levels at the home. We were told that an increase in staffing hours had been agreed with immediate effect and a new tool to calculate the hours required to be employed would be introduced by the company shortly.

Most people were not able to speak to us about how safe they felt due to living with dementia. We observed people throughout the day and saw that they were comfortable and relaxed in the presence of staff.

All of the staff we spoke with had a good understanding about safeguarding people from harm. They could tell us about the different types of abuse and what they would do if they suspected abuse. This followed the provider's policy. All staff said that they felt confident to raise any issues or concerns that they may have. They knew where information was displayed that gave guidance about how to make a referral to the safeguarding authority.

The manager advises us of events of suspected or potential abuse and they keep us updated about the actions they have taken to address these concerns.

People's risks in relation to their care needs had been assessed. These risks were in respect of people's pressure area care, mobility and falls, moving and handling and nutrition. We saw staff following the risk assessment care plans for moving and handling people safely. We looked at the monthly weight charts and these showed that at least five people were at risk because they had lost between 3kg and 16kg in the previous three months. Action had been taken to investigate the causes of the weight loss and risk reduction plans were in place that care and catering staff were aware of and had implemented.

Nationally recognised screening tools had been used to determine people's risks. These included the 'Malnutrition Universal Screening Tool' (MUST) to help identify adults at risk of malnutrition or obesity, and the 'Waterlow Pressure Area Tool' that helped to determine whether people were at risk of developing pressure ulcers. One person's Waterlow score in relation to their pressure area risks had been incorrectly calculated between the months of June to December 2014. This meant that staff potentially missed that the person was at higher risk of developing a pressure ulcer. People's risks had been reviewed on a monthly basis.

Requires Improvement

Is the service effective?

Our findings

Some people did not receive the assistance that they required in a timely way. For example, we noted that staff placed a cup of tea and biscuits in front of a person during the morning. Their care plan stated that they required assistance with eating and drinking. Staff did not assist them. The person's cold cup of tea and uneaten biscuits were taken away by staff at lunch time.

We saw that people did not get all the support they needed, with one person's uneaten breakfast being removed when their lunch was taken in to them. Staff told us they hadn't had time to go back and assist the person to eat or to fetch the tray. Another person was seen to have a blackened banana sandwich left over from breakfast, which had not been removed until lunchtime.

We observed the lunchtime experience in the dining room and noted that approximately 16 people were eating in there, with the remaining 24 eating in their rooms. People were assisted by staff, including housekeeping and activities staff, to eat their meals in the dining room and some enjoyed a good experience. However, we saw two people were given their meal but there was no-one available to assist or prompt them until their lunch had gone cold. Both required verbal and some physical assistance to eat. We were aware that staff were still rushing to get lunch to people in their rooms 45 minutes after lunch had started. One visitor expressed to us their concerns that their relative had been sat in their room all day and had not been supported to eat their lunch until the end of the lunchtime period, by which time it had gone cold.

These concerns constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of this inspection report.

Two of the care plans that we reviewed stated that people were at risk of malnutrition. We noted that the care and support given to these people met their needs appropriately. One person required a soft diet and fortified meals and another person required a minimum of one and a half litres of fluid to ensure they remained hydrated. We saw that the person was assisted with their drinks throughout the day and at regular times. However, the person's fluid chart had significant gaps in it and staff would not have been sure whether the person had received enough to drink.

People had a choice about what they wished to eat. We saw that most people who required assistance to eat their meals received this although not always in a timely way. We observed one care worker assist a person to eat who was cared for in bed. They did this compassionately. They actively encouraged the person to eat in a respectful manner. We saw that the person was eating food that had been pureed separately. This was to ensure the person could taste the individual food items. The person's care plan stated that they required 'thick and easy' compound to their drinks due to them having a risk of choking and we saw that this was added accordingly.

People were supported by staff with the necessary skills, knowledge and experience to meet their needs effectively. Staff described the training and development that was available to them, including nationally recognised qualifications in care. Staff received training that was relevant to their role. For example the activities co-ordinators described completing courses about developing and providing activities appropriate to older people and those living with dementia.

Staff told us they received training that related to the needs of people living with dementia. We saw that a training plan was in place so that staff knew when their update training was due. Staff confirmed that they felt well supported through regular supervision, which helped them to improve their practice. The training and supervision staff received enabled them to understand and meet the needs of people at the service.

We observed, at all times that staff asked people for their verbal consent before delivering any care or support. This included asking before placing protective aprons on people before they ate their meal and asking if it was alright to assist someone to transfer to a wheelchair so they could go to their room before doing this.

We were told by the senior administrator that an application to deprive one person of their liberty had been made to the authorising body. An assessment of the person's capacity had been made, together with decisions about how staff should act in their best interest. Staff confirmed that they had received training about the Mental

Requires Improvement

Is the service effective?

Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They were able to explain the principles of the MCA and how it applied to the way they cared for people at the home.

We saw evidence in the care plans we reviewed that people had access to healthcare services and received on-going health support. There was documentation in relation to people's hospital visits, as well as interaction with others including their GP, district nurse, speech and language therapist, chiropodist and optician. Records showed that referrals to health professionals were made in a timely way.

Good

Is the service caring?

Our findings

Throughout our inspection, we saw at all times that staff were kind and caring towards people. It was evident that staff knew the needs of the people they cared for. Staff were compassionate and gave people as much time as they could.

We observed one member of staff supporting a person who was anxious. They sat and spoke with the person about their past history and effectively reduced the person's distress. We saw other members of staff support other people who became distressed or anxious. Again, staff were considerate and kind towards them. They sat and held people's hands. They took their time supporting people and reassured people appropriately.

We witnessed people being given drinks and biscuits and staff taking the opportunity to engage specifically with that person. Staff worked hard to raise a smile and to get people engaged in conversation in the lounge so that people felt more animated whilst they were in there. Unfortunately, staff were not able to maintain this level of interaction for long because they were often required to support people in other areas of the home.

We observed that the care and support given to people. People were involved in deciding where they wished to spend their days and whether they wished to join in with different discussions. For example, when a carer was re-positioning a blanket on a person who was sleeping, the person awoke and the carer asked them what they would like to do. Another carer assisted to move the person and they were given choices about where they would like to spend their day.

We saw that staff listened to what people said and involved them as much as possible in decision making around their care and daily living. People had options explained to them and where necessary they were supported to make decisions that were respected by staff. Where people did not have the capacity to get involved in decision making their representatives acted on their behalf.

We noted that staff always knocked on people's doors before entering their rooms. People's dignity and privacy was respected and promoted at all times during our inspection. People were discreetly asked whether they required assistance to go to the bathroom. People were assisted appropriately and people's independence was promoted where possible. Personal care was provided behind closed doors.

Requires Improvement

Is the service responsive?

Our findings

Most people were not able to be involved in planning their care although some were able to make decisions around daily living. One family member told us they were consulted about their relative's care and support and were kept informed of any matters affecting them. The care plans were person centred and staff demonstrated that they understood how individual people liked to live and about the things that were important to them.

We spoke with two visitors during the course of this inspection. One visitor spoke very positively about their relative's care. They told us that staff were good at informing them of their relative's progress. They also spoke about the support that had been given to their relative when they had been very poorly recently. One visitor said, "They do so much for [person]. The staff are good at telling me about how well [person] is doing". Another visitor spoke about their concerns that their relative spent all day in their room and staff did not always attend to them in a timely way.

The staff we spoke with had a good understanding about the needs of the people they cared for and supported. Staff could adequately explain the content of people's care plans and how people's needs should be met. Staff told us that the problem in meeting people's needs was due to there being inadequate numbers of staff on duty. We observed that this was the case. People were not attended to in a timely manner.

Daily reports were kept in the care plans that were accessible to all staff. Separate daily records were kept in respect of activities the person had joined in with during the day. However, charts such as fluid and repositioning charts that were kept in people's rooms were not being consistently completed. All of the charts had significant gaps in them. We asked staff and the deputy manager about this to try and determine whether people were not repositioned appropriately or people were repositioned but staff failed to document this. Staff told us that it was a combination of both. They said that there were not enough staff to ensure people were repositioned every two or four hours according to their needs. They said that they thought that sometimes, staff 'forgot' to document that they had repositioned someone. This meant that there was a risk that staff would not know whether the person had received the care they needed.

We reviewed people's care plans and saw that their personal histories were well documented. It was evident that staff had read people's personal histories as they spoke with people about them. People's interests and hobbies had been documented, as well as their likes, dislikes and preferences.

During our inspection the activities coordinators did try to engage people with activities that they enjoyed doing. However, due to there being insufficient numbers of staff, and the activities coordinators helping people with their personal care, people's social needs were not met. We did see the activities coordinators chatting with people and making people laugh and smile, but no organised activities were undertaken. We were satisfied that this was due to the lack of staff and not a lack of commitment or competence on behalf of the activities staff.

People were unsupervised for periods of time and those sat in the lounges were either asleep or sat with music playing and no visual stimulation or activity. People in their rooms received no stimulation and only intermittent visits from staff to check they were safe or to give them food and drink.

We visited a number of people's bedrooms and saw that they were individualised. They contained people's photographs, pictures and soft furnishings. Some people had brought their furniture into their room so that they were surrounded by things that were meaningful to them. All of the people we spoke with said that they were happy with their room.

The service had a complaints procedure displayed in the entrance hall, however it was partially obscured by an information stand. The complaints procedure contained contact details in the event the complainant wished to take their concerns further. Visitors to the home we spoke with knew how to make a complaint and would be able to do so if they felt it was necessary.

Requires Improvement

Is the service well-led?

Our findings

The registered manager at this home worked part time and was currently supported by a deputy manager with little management experience who has been in post for four months. During a telephone conversation with the manager after our visit, we were advised that a trainee manager was due to take up post the following week. Their role was to support the manager with the management and administration of the home.

At the time of our inspection the registered manager had been absent for three weeks and was not available at our visit. The home was in the charge of the deputy manager. They said that they were 'working the floor' on the day of our inspection. This was to cover a shortage in staff due to sickness. There was a lack of oversight and support from the provider for the deputy manager in the absence of the registered manager. Periodic support was provided by a deputy manager from another of the provider's homes. The deputy manager was struggling to manage the service due to a lack of seniority and the impact of poor levels of support.

We were provided with copies of the staff rotas for the period 15 December 2014 to 13 January 2015, the date of this inspection. Calculations based on the information provided showed that there were 14 day shifts and 11 evening shifts when the home was understaffed by at least one care assistant. There were also two occasions when only two night care staff were on duty according to the records provided. This meant that management systems in place to cover staff absences were not effective.

During the course of this inspection we noted that staff at times lacked clear direction. They were not always sure about who was responsible for various tasks and this meant that some were missed or not recorded properly.

The staff we spoke with told us that they felt the management of the service required improvement. They said that the registered manager was supportive but not at the home very often. They told us in their view that the deputy manager had been 'thrown in' to their job with insufficient support. Staff told us that they did not feel there was any leadership within the service, that there was no structure and that nobody took responsibility for the service or the quality of it. Staff told us that they felt the home would be 'excellent' if the staffing numbers were increased and there was consistently good management and leadership.

All of the staff we spoke with said that they felt the service and the quality of it was not audited as it should be. We found that this was the case for the management of medicines. The deputy manager and staff told us that no one took responsibility for auditing medicines because they did not have the time. It was evident that medicines had not been audited due to the number of errors and concerns we found.

These matters were a breach of Regulation 10 (1)(b)of the Health and Social Care Act 2008 (Regulated Activities) 2010. You can see what action we have told the provider to take at the back of this report.

During a telephone conversation with the registered manager after our visit, we were told that it had been acknowledged by the provider that staffing levels were too low and that a request had been made to increase the levels so that people's needs could be met.

Staff told us that they received regular supervision, when they could discuss issues relating to their role. We were also told that frequent team meetings took place relevant to roles when information was shared and issues discussed to improve the service and experiences of people living at the home.

We looked at the audits completed by the home to assess whether they provided a quality service. Monthly audits were taking place in respect of the care profiles. We saw a quality standards audit undertaken in November 2014 that considered the experience of people living with dementia. There was also a mealtime experience checklist that concluded people enjoyed good experiences, although this did not correspond to the lunchtime experience on the day of our inspection for all people living at the home. Audits of accidents took place with continuous monitoring of times and locations of accidents so that any patterns could be established and risks reduced.

The service sought the views of people using the service and their families. The provider sent out quality satisfaction questionnaires annually to people and their families and the outcome was displayed on the home's website.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use the services were not protected against the risks associated with the management, administration and recording of medicines. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risks associated with inadequate managements oversight of the day to day management of the service. Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected against the risks associated with inadequate support when eating and drinking. Regulation 14.

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.