Mr Barry Potton

Asquith Hall EMI Nursing Home

Inspection report

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Ratings

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

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

At previous visits to the service in November 2013 and January 2014 we had found improvements were needed to ensure staff worked within the requirements of the Mental Capacity Act 2005 (MCA) when supporting people to make decisions about their care and treatment. We also found people were not always protected from the risks associated with medicines. In January 2014 we found the service had not been protecting people from abuse as staff had not followed multi-agency

Summary of findings

safeguarding procedures. This had led to safeguarding incidents not being reported to the local safeguarding authority. We issued compliance actions requiring the provider to make improvements. The provider sent us an action plan detailing the actions they would take to make necessary changes.

Asquith Hall provides nursing and personal care for up to 53 people with dementia and mental health issues. The service is divided into two units on separate floors. There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

Although we found improvements in the management of medicines we found there were occasions when people had not been protected against the risks associated with medicines. This included gaps in recording and insufficient checks when people returned from hospital with changes to their prescriptions. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People were protected from harm and risks were managed to keep people safe. Where people's freedom was restricted in order to keep them safe the provider had made Deprivation of Liberty Safeguards applications. Safeguarding concerns had been reported to the local safeguarding authority as required and CQC had been notified of these.

Staff were employed in sufficient numbers to keep people safe and meet their needs. Staff had received training to give them the knowledge and skills they needed to care for people who lived at the service. The provider monitored training to check this was up to date.

People were supported to have a balanced diet that met their nutritional needs. People told us they were satisfied with the food at the service. Risks to people's nutrition were monitored and information was shared with those staff involved in supporting people with eating and drinking.

People had access to health professionals when they needed specific medical and health advice. The advice of health professionals was recorded and followed by staff in order to meet people's health needs.

Staff were caring and knew the people they cared for well. Staff spoke positively about the people they supported. People and their relatives confirmed they were involved in care planning and care reviews allowing them to be involved in decisions about their care and treatment. We observed interactions between people and staff where people were treated kindly and their dignity was protected.

People received care that met their individual needs and preferences. Activities were meaningful and tailored to the individual.

The service encouraged people to express their views through consultations and surveys. We saw changes had been made to menus and staffing arrangements following feedback from surveys.

The registered manager was not present during our inspection. The service was led by a service manager who had a clear understanding of the service's strengths and a plan for continued improvement.

Learning from incidents and feedback had resulted in changes to people's care and staff practices where necessary. This had been managed positively. Staff told us they felt supported by the management systems in place.

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 always safe.

Medicines were not consistently safely handled. Appropriate checks were not completed and recorded on people's return to the home from hospital to ensure any changes to people's medicines were promptly identified and action taken. Medicines record keeping did not always support and evidence the safe handling of medication because there were occasional gaps or errors in the medicines administration records.

People were protected from abuse. Staff told us they were able to recognise abuse and felt confident in reporting any concerns. Incidents of safeguarding had been reported to the local safeguarding authority. The service was meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

There were enough staff to safely meet people's needs. The service manager regularly reviewed staffing against the needs of people who used the service to check appropriate staffing levels were maintained.

Is the service effective?

Good

The service was effective.

Staff had received training to allow them to care for people effectively. Staff told us they felt supported in their roles.

People were supported to maintain a healthy balanced diet. Catering staff worked with the care team to make sure they had up to date information about people's dietary requirements and people received the support they needed to access food and drinks.

People were supported to access a range of health professionals where they needed additional support with their health needs. Staff followed the instructions of health professionals to make sure people's health needs were met.

Is the service caring?

Good

The service was caring.

Staff knew the people they were caring for well. Life histories had been used to help staff understand people better and to inform their approach to people's care.

People who used the service and their relatives told us they were happy with the care provided. People were supported to be involved in their care and decision making.

Summary of findings

Staff respected people's need for privacy and dignity. We observed interactions that were kind and considerate.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed with them and their family members to check care was appropriate and met people's current needs.

People had access to meaningful activities that were tailored to their agreed goals.

People told us they could raise concerns and that they were listened to. The service manager told us how they used feedback from concerns and complaints to share learning across the staff team.

Is the service well-led?

Good

The service was well led.

The service was managed by a service manager who had worked with the staff team to promote a positive learning culture within the service.

Staff we spoke with were clear about their roles and responsibilities and were positive about working at the service. Staff morale was good.

Learning from audits, analysis of incidents and feedback from people who used the service and others was used to review practice and to improve the quality of the service.

Asquith Hall EMI Nursing Home

Detailed findings

Background to this inspection

This inspection team consisted of four adult social care inspectors, a pharmacy inspector, a specialist professional advisor in dementia care 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. The expert by experience had some knowledge of mental health services.

Before our inspection we reviewed all the information we held about the service. We considered the nature of safeguarding alerts that had been made and any other information that had been shared with us. We asked the local Healthwatch and commissioners for information and were not made aware of any additional concerns. We asked the provider to complete a Provider Information Return and used this to inform our planning. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We inspected the home on the 15 July 2014. At the time of our visit there were 53 people living at the service. We undertook informal observations of care in the lounge and dining room areas to help us understand the experience of people who used the service. We looked at all areas of the service and spent some time looking at documents and records that related to people's care and the management of the service. We looked at eight people's care records.

During our visit we spoke with 17 people living at the service and seven relatives of people who used the service. The registered manager was not present at the service during our inspection. However, we spoke with the service manager and looked at inspection records.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

At our previous visit we found people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. At this visit we found the service's arrangements for handling medication had improved but there were some occasions where people had not been protected against the risks associated with medicines. All medicines were administered by qualified nurses. Regular medicines audits were completed and the manager had started to carry out competency assessments with staff to help ensure medicines were safely handled, in accordance with the service's medicines policy. Any medicines errors were properly reported and investigated to try and reduce the risk of reoccurrence.

Assessments of people's individual medicines needs were included within people's care plans. Self-administration risk assessment and care plans were completed where people were supported to manage their own medication. Appropriate arrangements were in place where covert (hidden) administration of medication was used to ensure this was assessed and monitored in order that people's best interests were protected. Written individual guidance was in place about the use of medicines prescribed as "when required" to help ensure these were offered and used appropriately.

The medicines administration records were generally clearly presented to show the medicines people had received. However, there were occasional gaps where medicines administration or the reason for non-administration was not recorded. One record we looked at showed that eye drops had been applied when the tube remained sealed; the nurse confirmed with us that this record had been signed in error. We saw a second record that had not been clearly completed to show the administration of a controlled drug.

Where new medicines were prescribed administration was normally started promptly. However, we found that appropriate checks were not completed and recorded on people's return to the service from hospital. Two records we looked at showed that treatment changes made whilst in hospital had not been continued on return to the service. The reason for this was unclear and nurses were unable to find any records to show that GP or prescriber advice had been sought, in order that people would receive the best treatment.

We found that the homes medicines arrangements did not protect people against the risks associated with medicines. This meant there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of the report.

At our inspection visit in January 2014 we found incidents had not always been reported to the local safeguarding authority. Following this visit we had been notified of safeguarding incidents that had been reported in accordance with the West Yorkshire Multi-Agency Safeguarding Policy.

At this inspection we saw copies of safeguarding alerts that had been raised with the local safeguarding authority. These included incidents between people who used the service as well as an injury caused by damaged bed rails and a person developing pressure ulcers. These showed safeguarding alerts were being made appropriately.

The safeguarding file provided staff with all the information they needed to make an alert. Staff said they had received their mandatory training in safeguarding and were aware of how to respond to and prevent safeguarding issues. People who used the service told us they felt safe. One person told us, "I feel safe and comfortable here." Another person said, "It's safe and secure. I am confident I could report anything."

The service manager and staff we spoke with were knowledgeable about the requirements of the Mental Capacity Act 2005 (MCA). The MCA sets out what must be done to make sure the human rights of people who may lack capacity to make decisions are protected. Where people's freedom was restricted in order to keep them safe the service manager had made referrals for Deprivation of Liberty Safeguards (DoLS) authorisations. At the time of our visit the service manager had made 27 DoLS referrals. On the day of our inspection four best interest assessors attended to complete assessments with four people who had been referred to the local authority for them to consider whether the measures taken by the service to keep them safe was in accordance with the MCA.

Requires Improvement

Is the service safe?

Doors, including bedroom doors, were controlled electronically. People who wanted independent access to their bedrooms were provided with wrist fobs to allow them to gain entry to their own bedrooms. This allowed people to access their personal space independently whilst minimising the risk of people who were disorientated entering other people's rooms by mistake.

Where people who used the service experienced risks to their health and well-being due to their physical or mental health needs, these had been identified by the service. Care plans provided information for staff about how to support people to manage risks whilst considering preferences and wishes. There were clear procedures for staff to follow in the event of an emergency. This included personal evacuation plans that identified the needs of each person to support them in the event of a fire.

Everybody we spoke with told us there was sufficient staff to meet people's needs. The service manager explained they reviewed staffing levels against the dependency of people who used the service to make sure staffing levels were changed as necessary. The service was staffed above dependency levels to prevent staffing falling below required levels in the event of short notice staff absence. There was no difference in staffing levels at weekends with the exception of reception staff. The service manager explained contingency plans were in place for adverse weather. This meant the provider was able to maintain consistent levels of staff to safely meet people's needs.

The provider had safe recruitment procedures in place. Staff we spoke with told us they had followed a recruitment process and had waited for pre-employment checks to be completed before they started work. We saw copies of references and Disclosure and Barring Service (DBS) checks on staff files. This reduced the risk of the provider employing staff who were not suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff we spoke with told us they received induction and on-going training. One staff member told us, "I had an induction and did training, moving and handling and safeguarding. I then shadowed for three days." Domestic staff we spoke with told us they received the same training as care staff. Every staff member we spoke with told us they felt they had sufficient training, including annual refresher training where necessary, and felt they had the knowledge and skills they needed to meet people's needs. One staff member told us, "I love my job and when you like your job you want to learn."

We saw a copy of a training record the provider used to monitor the training completed by staff. This confirmed staff at all levels within the service had received training including dementia awareness, Mental Capacity Act and safeguarding of vulnerable adults. The matrix showed that the training for 98% of staff was up to date.

People who used the service were supported to have a balanced diet and had access to meals and snacks throughout the day. People we spoke with told us the food was consistently good.

We spoke with the cook who showed us an information board in the kitchen that identified those people with specific dietary requirements. The cook told us they were provided with information about people's weights on a monthly basis so they could amend recipes where people needed additional fortified foods. They explained they were not limited by a food budget stating, "If they want it they can have it. (Person's name) likes kippers so we get them for him."

We observed the lunchtime service and saw people were supported to eat where necessary in a way that was appropriate to their needs. People were offered choices about where to sit and the food they wanted to eat. Menus were provided in pictorial format to help people choose what they wanted to eat. One person was mobile throughout the lunchtime service and we observed staff providing them with food to eat at regular intervals. The mealtime was relaxed and unhurried. We saw people who were prescribed food supplements were given these as prescribed. One relative we spoke with confirmed they were satisfied with the quality of food and told us their family member had gained weight since moving into the service.

Drinks were available throughout the day and staff confirmed they had access to snacks at all times for people who were hungry throughout the day and night time. Where people were at risk of weight loss or dehydration we saw their dietary intake was monitored and recorded.

People told us they felt they could discuss any concerns about their health with staff. Care records showed people were involved in care consultations with staff where their health and care needs were reviewed. Where risks had been identified to people's health and well-being, risk assessments were in place and were reviewed regularly. When monitoring showed people were at continued or increased risk to their well-being, for example, from malnutrition or skin integrity, referrals had been made to external health professionals.

Care records showed people had been supported by their GP, and where necessary members of the community mental health team, dieticians and tissue viability nurses. Where health professionals had provided specific advice and guidance for the person this was recorded in their care plan. Daily records showed people were supported in accordance with their care plan.

Good

Is the service caring?

Our findings

People who used the service told us staff were caring and they were satisfied with the care and treatment they received. We spoke with one person who told us, “The staff are lovely.” When the person told us they did not feel very well a staff member approached them to explain they had just had their medication and reassured them they should start to feel better soon.

We observed kind and individual care throughout our visit. Staff understood people’s needs and life histories had been used to inform staff’s understanding of people’s behaviour. For example, we saw in one person’s care records that they became agitated if people were not doing as they wanted them to. The person sometimes displayed behaviours that were challenging to staff. Their care records provided details of their former profession explaining why the person behaved as they did and the steps staff should take to diffuse any potential situation.

One relative told us, “They (staff) try so hard; they are so caring. It’s genuine; they really care and know (my family member’s) individual needs.” Another relative said, "I sit here and listen and I have never heard one unkind word from the staff to a resident." When speaking about their family member another visitor told us, "This is a first class service. She came here on an ‘end of life pathway’ but they have brought her back."

Staff were knowledgeable about people’s personalities, preferences and needs. Staff we spoke with all spoke positively about the people they supported and showed compassion. One staff member told us, “You have to put yourself in their shoes.” A member of the ancillary staff team told us they thought care staff were kind. They told us, “I think the staff are good. Many of them care for people as though it was their parent or grandparent.”

People who used the service and their relatives told us they were involved in their care. People were supported to make decisions when they were able to do so. Where people lacked capacity to make decisions about their care and support we saw records of mental capacity assessments and best interest decisions. Staff we spoke with told us they always considered what had been agreed in the person’s best interests when providing care interventions.

People were supported to be as independent as possible. The service manager explained they used positive risk taking to support people to develop their independence. This included supporting people to access the community.

Staff told us they loved their job and provided good quality care to people. They told us they treated people with dignity and respect and involved them and their relatives in their care plan. We saw the views of people and their relatives were recorded in their care plan and progress notes. We saw staff knocked on bedroom doors before entered and spoke gently and listened to what people were saying.

Relatives and friends were encouraged to visit without restriction. One person told us, “My four year old grandson made this bracelet. He comes to see me; we go in my room where I have a box of toys for him to play with on top of the wardrobe." A relative of another person told us they were a partner in the care of their spouse and the support they provided to them at mealtimes was recorded within their care plan. A third visitor told us, "Staff keep me up to date on what's going on and welcome me visiting. I can visit any time."

Good

Is the service responsive?

Our findings

We spoke with one relative who told us, "She is always well looked after. I feel able to speak up and have done during her reviews."

Care records showed initial assessments had been completed prior to people entering the service. Care plans reflected people's assessed needs. Where risks had been identified appropriate risk assessments were in place. Daily records reflected people's needs and showed care was provided in accordance with the person's care plan.

People's care records were reviewed regularly and actions recorded where there had been a change in people's needs. Records showed people and their relatives had been involved in 'care consultations'.

Where people agreed, they worked with activities staff to set a personal goal. This allowed people to receive support that was tailored to their specific needs and preferences. For some this focussed on social activities whereas other people were working to develop their independent living skills with an aim to future independent living. Activities staff told us they supported people to complete activities in line with their preferences. One person confirmed this saying, "I'm a baker and we made biscuits which I decorated."

People were supported to access the community for meaningful activities. This included people attending a fortnightly dementia café in Halifax. A greenhouse had been purchased prior to our visit due to the success of a gardening club. Activities staff told us they had recognised the need for gender specific activity for some people and had started a consultation about the demand for a, "Men's shed."

In addition to planned activities there were wall mounted activities and rummage boxes for people to access independently. Staff told us some people did not want to engage in activities but accessed a newspaper service to keep up to date with current news. We spoke with one person who told us, "I like to go out." We saw this person was out for a walk as we were leaving following our inspection.

Menus had been reviewed in consultation with people who used the service. Staff explained this had been done through meetings with people who lived at the home and one to one consultations. We saw pictorial communication and spell boards that were used to support people who were not able to communicate verbally to participate in consultations about the quality of the service.

Relatives told us they felt able to raise concerns. One relative told us they had shared concerns regarding their family member's medicines stating, "I have to fight for his human rights. They listened to me and now they give him his tablets before he gets up."

There was a complaints policy in place at the service. Staff we spoke with explained how they handled complaints using past examples. The service manager told us a complaint that had been made by a member of the public regarding an incident in a neighbouring park had been escalated to the local safeguarding authority.

We spoke with the service manager about how they used concerns and complaints to improve the quality of care. They told us some concerns had resulted in safeguarding alerts rather than complaint investigations. The service manager told us they had asked the local safeguarding authority for further input in order to complete a thorough feedback and identify any learning for staff.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of our visit. However, the day to day running of the service was overseen by a service manager. Staff we spoke with told us they were clear about their roles and responsibilities. Staff on duty were dressed in different colours of uniform. This made it easier for people who used the service and visitors to identify the role of each member of staff. Staff told us they believed in the values of the provider company.

The majority of staff we spoke with told us they received regular supervision. Where staff had not had recent supervision they told us they felt supported and could seek supervision and guidance from both nursing staff and management as required.

The service manager had management oversight of the service and had implemented changes to improve practices since our last visit. They explained how they had worked to change the culture of the service in relation to safeguarding. The service manager explained safeguarding had previously been perceived as a negative process and responses to incidents had been dependent on the thresholds of nurses. The service manager met regularly with the local authority safeguarding team to drive improvement at the service. They explained how they had analysed previous incidents to improve responses to safeguarding incidents. This had resulted in improved practice regarding safeguarding and better understanding for those staff we spoke with.

The provider had taken proactive steps to ensure the service was able to respond to a supreme court judgement regarding the Deprivation of Liberty Safeguards (DoLS). This was not related to this service but the provider was aware of the possible implications for the service. They had employed a consultant to train nurses to ensure the wording of DoLS documentation was accurate to prevent delays in authorisations. Systems had been developed to provide oversight of the progress of DoLS authorisation requests. This involved administration staff tracking the progress of referrals.

The service manager analysed accidents and incidents to identify any patterns or trends. Due to the mental health needs of some people who used the service there were regular incidents where people expressed behaviour that challenged the service. Staff had received training in de-escalation techniques to provide interventions to reduce the risk of incidents occurring. The service manager explained CCTV had been fitted to the corridors within the service following consultation with people who used the service, visitors and staff. This had been done following incidents between people who used the service that had not been witnessed by staff. Staff also maintained a presence on corridors where possible to minimise the risk of incidents occurring between people.

Audits were completed in accordance with the provider's quality assurance policy. Where audits had identified the need for improvements these had been addressed in team meetings. Although there was a record of provider monitoring visits these did not give details of the areas looked at or any checks of the authenticity of audits completed by the manager.

Consultations included a quarterly satisfaction survey for people who used the service and a relative / visitor survey that had been completed in June 2014. Although comments about the staff were all positive there were some negative comments from relatives about staffing levels at weekends and wait times when people needed assistance to use the toilet. The service manager told us the provider had increased ancillary staffing and had changed access arrangements to reception for staff at weekends in response to the comments made.

There was a culture of learning and development at the service. Staff had been appointed as 'champions' for dignity and dementia to share learning and good practice across the whole team. Minutes of staff meetings showed meetings had been used to share feedback from surveys and to address learning from incidents and audits. Practice issues were also discussed that gave staff clear expectations about their practice. For example, the minutes of a staff meeting in June 2014 showed there had been discussion about the need for person centred practice and a move away from 'task oriented care'.

There was recognition of the need for continuous improvement. The clinical lead nurse told us they were working with staff to improve communication and support when staff had been involved in situations that had challenged them. Care records showed that, where people who used the service had behaviour that was challenging to staff, their care plans were reviewed and risk assessments updated as necessary.

Good

Is the service well-led?

The service was working with the community matron to meet the aims of NHS Calderdale's Clinical Commissioning Group's Quest for Quality in Care Homes initiative. The aim was to improve the experience for people through improving the clinical skills of nurses; protocols to drive improvement; improved documentation and developing a pathway approach to help people move on where their needs reduced.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by the means of appropriate arrangements for the obtaining, recording, handling, using, safe keeping and safe administration of medicines used for the purposes of the regulated activity.**