Ashfield Specialist Care Limited

Ashfield Nursing Home

Inspection report

Beach Avenue
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Nottingham
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Ratings

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

Overall summary

We inspected the service on 14 and 15 October 2015. Ashfield Nursing Home is registered with the Care Quality Commission to provide accommodation for up to 40 people with mental health needs and dementia. On the day of our inspection there were 27 people living at the home.

Since the time of the last inspection the service had changed its name and was owned by a new provider. A new manager had been appointed and they had registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in July 2014 we found that improvements were required in relation to implementing the principles of the Mental Capacity Act 2005, managing medicines safely and assessing and monitoring the quality of the service provided. The provider, at that time,

Summary of findings

sent us an action plan detailing what action they would take to become compliant. The new providers had continued to address the issues and we identified and improvements had been made.

People who used the service told us that they felt well looked after. People's representatives and visitors to the home told us that people were safe.

We found that staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were managed to keep people safe.

There were sufficient staff on duty to meet people's needs safely although at times, staff were rushed and this compromised the overall quality of the service provided. The process of administering medicines was safe. Staff were recruited through safe recruitment practices.

Staff received regular and ongoing supervision and support. An induction for staff was provided although staff had to wait to access some training courses. Training opportunities were improving to provide staff with the skills and understanding to carry out their roles effectively.

Overall people enjoyed a varied and balanced diet and plans were in place to improve the dining experience for everyone who used the service. People were supported to receive any health care they needed and advice provided by professionals was acted upon.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in the decision making processes and care was personalised to meet individual needs. Care plans were detailed although records of decision making had not all been reviewed to reflect that they were still current.

Activities were currently limited but were improving. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising any concerns with the registered manager or the providers and that they would take action. There were systems in place to monitor and improve the quality of the service provided.

People living at the home and the staff team had opportunities to be involved in discussions about the running of the home and felt the manager provided good leadership. People had been consulted and involved in plans to develop and refurbish the home.

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?
The service was not consistently safe.

The risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as and when prescribed.

Overall staffing levels were sufficient to meet people's needs.

Recruitment procedures ensured that only people suitable to work with vulnerable people were appointed.

Good

Is the service effective?
The service was not always effective.

People's rights were protected under the Mental Capacity Act 2005 although records could be improved to reflect that decisions were still current.

Staff received appropriate support and induction. Training opportunities were improving.

People received sufficient to eat and drink although the dining experience could be improved for some.

External professionals were involved in people's care when requested although decisions for referrals were not always evident.

Requires improvement

Is the service caring?
The service was caring.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care. Care was personalised and reflected individual needs.

Good

Is the service responsive?
The service was responsive.

People's health was monitored and responded to appropriately when needs changed. Joint working arrangements were productive.

Activities were being developed and improved.

People who used the service were comfortable to approach the manager and members of the staff team with any issues. complaints were dealt with appropriately.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The manager was knowledgeable about the strengths and needs of the service and they sought the views of people who used services, their relatives and staff.

Staff were well supported and had opportunities to review and discuss their practice regularly.

There were procedures in place to monitor the quality of the service and where issues were identified there were action plans in place to make changes and improvements.

Ashfield Nursing 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 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 14 and 15 October 2015 and was unannounced.

The inspection team consisted of two inspector's, a specialist nursing advisor who assessed people's nursing needs 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 information the provider had sent us including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection spoke with nine people who used the service about the care and support they received. We spoke with the providers and the registered manager. We spoke with ten staff and five visitors to the home. We looked at six care records, six staff training and recruitment files and other records relevant to the running of the service. This included policies and procedures. We also looked at the provider's quality assurance systems.

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.

Good

Is the service safe?

Our findings

At the time of our last inspection in July 2014 we found the provider was not managing medicines safely. They sent us an action plan telling us how they would improve. At this inspection we found that improvements had been made.

People told us they were well looked after. Relatives told us that they felt people were safe at the home. One person told us, "They are safe and happy here." Another relative told us, "People are definitely safe here." Staff told us that they thought that people were safe and they were confident that they had the knowledge and skills to keep people safe. One staff member told is, "I would put my mum here. That's how confident I am that this home is safe."

Two out of the three staff we spoke with, told us that they had not received external training in how to protect people from abuse but had received full training by the registered manager who was competent to deliver adult safeguarding training. Staff thy all demonstrated a good knowledge of how to recognise and respond to allegations or incidents of abuse. They understood the different types of abuse and the signs to indicate abuse was happening. All staff knew how to report allegations of abuse and the registered manager had made referrals and worked with other agencies to keep people safe.

Risks were being managed appropriately. Assessments of risks were seen on all files reviewed and these included the risk of falling or developing pressure sores. Staff were aware of action they needed to take to keep people safe in these areas. We saw that when individual risks had been identified these had also been documented in care plans. We looked at three individual risks associated with behaviours observed at the time of the inspection. Behaviours were supported by guidance for staff to keep that person safe and staff referred to the guidance when we spoke with them.

Medicines were safely managed. People told us that they received the medicines they needed on time and when they needed them. Relatives confirmed this. One visitor to the home told us that staff kept them informed about their relative's medication. They told us, "They let me know anything that's going on." A person who used the service was able to tell us what medicines they were taking and why they were taking them. Staff told us they had received training in safe handling of medicines and had regular supervision on their competency

During our inspection we saw that the medication trolley was kept in the home's main entrance. The registered manager was reviewing the suitability of this because, as well as the area being busy and often very warm, the administration records were easily accessible to people who did not need to see them. We observed a member of staff administering medicines. Medicine was prepared at the trolley and then taken to the person receiving it. The trolley was locked every time the staff member moved away from it. We saw that administration records were completed upon return to the trolley.

We saw how the registered manager and the provider carried out regular checks to medication arrangements. We saw that the auditing process identified deficiencies in relation to running totals of medicines. Records showed that the issues remained ongoing and had been identified on subsequent audits. The provider told us that the practice of recording totals was an additional safeguard and was not necessary to ensure safe recording. They took immediate advise from a pharmacist who confirmed this to them. They then removed this extra check from the process. We saw that a local pharmacist had recently carried out an audit of medication. They had made minor recommendations which had been acted upon.

Arrangements were also in place for the safe storage and recording of controlled drugs and medication that required refrigeration.

Staff who were involved in the ordering of medicines to the home told us that arrangements were efficient although there was no evidence that medicines were checked upon delivery.

We saw that accidents and incidents were documented and reviewed. This meant that any required changes to keep people safe could be considered and actioned. The registered manager referred incidents to outside agencies appropriately, worked alongside other professionals and took appropriate action to keep people safe.

Most people thought that staffing levels were adequate although some people said they sometimes had to wait for support, One person told us, "I put my buzzer on…they eventually come." Relatives did not think that people had

Good

Is the service safe?

to wait long for support although one relative told us, "They [staff] don't have a minute. They are on the go all the time." We observed that staff were very rushed, especially at lunch time. Staff were confident that the number of staff on duty at any one time was adequate to keep people safe. They also said that staffing levels were an area where they had noted improvements. The registered manager told us how staffing levels were being monitored and increased in line with new admissions.

We looked at the recruitment files of three members of staff who had recently started working at the home. The provider had gathered the majority of required information to reflect a safe recruitment process. However there were no records to show they had explored gaps in the employment history for two out of the three staff whose files we reviewed. The registered manager confirmed that the conversations had taken place but had not been recorded. They told us that they would update their files accordingly.

Procedures were in place to protect people in the event of an emergency, such as a fire, and we saw how regular checks and routine maintenance of the home environment and equipment ensured people were protected. Staff could explain the procedures they followed to raise issues that required attention. Housekeeping staff told us that they had sufficient resources to ensure they could keep the home clean. This included access to cleaning products and personal protective equipment.

Requires improvement

Is the service effective?

Our findings

At the time of our last inspection in July 2014 we found that the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not always being implemented appropriately. During this inspection we found that improvements had been made.

People told us that staff met their needs in ways that they preferred. Staff listened to people's wishes and choices and responded appropriately. They understood the principles of consent. We heard staff ask people for their consent before they supported them. One person refused support for personal care and staff respected this. They told us that they would ask again later as the person often changed their mind. We met a family member who told us that their relative did not have capacity to make decisions. They told us they had been fully involved and consulted in relation to identifying their life histories, likes and dislikes. They were satisfied that staff, as a result of this information sharing, offered effective support in line with their relative's needs and wishes. Records showed that consent had been sought from people who used the service, in relation to managing medication and sharing information. Some records indicated that some decisions needed to be reviewed by family members although no timescales were given for this. Delays may mean that important decisions are not agreed and people's choices and preferences not acted upon. The registered manager told us that paperwork was being reviewed and updated to make the process more effective.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS is a code of practice to supplement the main MCA 2005. These safeguards protect people by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. A number of DoLS applications had been made by the registered manager. They told us about interim safeguards that were in place while they were waiting for a formal decision. The registered manager and the nurse on duty at the time of the inspection understood their role and their responsibilities in relation to DOLS, mental capacity and best interest's decisions.

Staff had a basic understanding of the principles of the Mental Capacity Act 2005. They told us that training was available and some confirmed that they had attended this. Staff told us that they were not routinely involved in best interest decisions. Senior staff told us that it was their role to cascaded decisions to care staff.

Staff were able to explain how they supported people with behaviours that may challenge those around them. Care records contained guidance for staff in this area. Overall staff understood what constituted restraint although some staff did not consider some safeguards to be 'restraints'. This suggested that more training may be needed to ensure staff did not knowingly restrict people they were supporting.

Staff told us that they received training and support to enable them to meet people's needs effectively. They recognised that there were still areas where their skills and knowledge needed to improve or be updated, especially in relation to moving and handling people. They were confident that the registered manager and the provider were arranging training to reflect this. One staff member told us, "There is a wide variety of training but we have had such a turnaround of staff that sometimes we have to wait for a while. It could be quicker." Other staff supported these comments.

Staff felt well supported by the registered manager and by the provider. They told us that formal supervision was taking place although some commented that they would like it more often. They all told us that the manager was approachable to talk to at any time.

A health professional who was working with staff to support people who used the service told us, "Staff are getting training and support. It's really positive. They have worked through issues." They went on to tell us how these changes had had a positive impact on people who used the service as they had been able to deliver effective care.

The registered manager told us they were reviewing the induction process. Staff we spoke with felt that the induction had given them a good insight to their role although some told us of delays waiting to access certain induction training. The registered manager told us that they were addressing this issue. One staff member told us, "The induction is good, especially if you are new to care."

People told us that they had plenty to eat and drink and most people said that they enjoyed what they had. One person told us, "Food is lovely." Another person said, "Food is nicely presented and laid out and nice and hot." Staff

Requires improvement

Is the service effective?

recorded what people ate and drank in order to monitor people's intake. Relatives were also involved in monitoring people's eating and drinking. One relative told us, "There is a record of what they [their relative] eat. They always put down what they have had. If I give them anything I have to tell them."

We observed lunch time in both the upstairs and downstairs dining room. The atmosphere at lunch time downstairs was relaxed and friendly. Staff sat with people while they ate their food. We found that, although people were offered a choice of main meal they were not given the opportunity to make other decisions. Meals were served plated and gravy was already on the food and jam was already on the rice pudding.

Upstairs (where there were fewer people being supported) the meal time experience appeared rushed. Staff were not able to sit with people while they ate their meal. Instead they offered support intermittently while doing other tasks. Two people ate their meal in the lounge. Again we saw that they had to wait for assistance. At one point a housekeeper came in and began cleaning around them. The registered manager told us that they had already spoken with staff about particular challenges and how they could resolve them. A staff member told us that they had had conversations with the provider about how improvements could be made.

Staff knew what people liked and disliked in relation to food and drink. One person told us, "They know what I like and there is always plenty to eat and drink." Care plans detailed people's likes and dislikes. We saw that when dietary supplements were prescribed they were given appropriately and recorded.

People were supported to access healthcare support when required including the optician and the chiropodist. Staff and relatives confirmed this. Staff told us that if they noticed that a person was unwell or their needs increased they told the nurse on duty in the first instance. The records we saw showed how people's changing needs were monitored by care staff.

Good

Is the service caring?

Our findings

People told us that staff were caring. A relative told us, “Staff are brilliant. Very kind. Nothing is ever too much trouble.” Another relative said, “What I do know is they care with a passion for my [relative].” A visitor told us, “They are all caring here. Staff are brilliant.”

We observed positive interactions between people who used the service and staff. People clearly felt comfortable with staff and interacted with them in a relaxed manner. Staff were warm and friendly. They spoke with people quietly using touch appropriately, especially when offering comfort and reassurance.

Staff knew people’s individual needs and preferences. They were able to use their knowledge to be compassionate and reassuring. They could help people to remain calm and contented. For example we saw one staff member redirect a person to a quieter area of the home as the room they were in was becoming busy. The person was visibly happier in the quieter environment. Another staff member comforted a person who wrongly thought their family were visiting. We spoke with a visiting health professional about a person who staff had recently supported. They told us, “They [the person who used the service] really did have the best care possible. Staff understand people’s needs here. They are marvellous.” They went on to say that staff were kind and caring.

Throughout the inspection we heard people expressing their views and wishes. We saw that staff listened to people. Staff told us that when people were unable to do this they relied on what they knew about people. Relatives told us that the provider sought their views when people were unable to speak for themselves. Relatives shared life histories, individual preferences and likes and dislikes. They told us that they felt listened to and involved.

Care records contained information which showed that people and their relatives had been involved in their care planning as far as possible. Advocacy information was available for people if they required support or advice from an independent person.

Staff promoted people’s individuality and this was important to people. One person liked to have their hair done a certain way. One person liked to wear their jewellery and one person liked to have their own chair. Staff told us that if people had specific religious or cultural beliefs they would be documented in their care plans and then they would be accommodated.

People told us they were treated with dignity and respect. A relative told us, “They [staff] maintain [my relative’s] dignity as best as they can. They all do.” Staff demonstrated that they understood these values in conversations with us and in practice. We saw staff take people to private areas to support them with their personal care. We also saw staff make discreet adjustments to people’s clothing while supporting them to move positions. Staff told us they always covered people when washing them, to maintain their privacy and knocked on doors before entering. We observed this during the inspection. A relative told us, “They [staff] always knock before entering and when they do personal care the curtain is always shut.” Everyone told us that people’s privacy was respected and promoted. We did however see that on occasions staff spoke ‘over’ people suggesting that further improvement in this area was required.

Staff told us they encouraged people to do as much as possible for themselves to maintain their independence. A relative told us that they [staff] always encouraged people to be independent. They said, “Sometimes it works, sometimes not. But they always try.”

People told us that their families and friends could visit whenever they wanted to. We observed that there were visitors in the home throughout the day of our inspection. Relatives told us that they were always made welcome. One relative told us they had been and shared a meal. People were also supported to maintain and develop relationships with other people using the service.

Good

Is the service responsive?

Our findings

People who used the service told us that they were able to say how they would like to be supported. We saw people telling staff what they wanted and staff responded in a timely manner to accommodate them. People told us that they could get up and go to bed when they chose and we saw examples of how staff supported this. Staff told us that they were aware of people's preferences but appreciated that people often changed their minds. They worked in a way that responded to individual needs and preferences.

People were assessed prior to, and at the time of their admission to ensure that the service would be able to meet their needs. One social care professional told us that they had recently worked with the registered manager and the staff team and that they had managed admissions "well". Reviews of care and support took place after admission to check that the staff team continued to meet people's needs. The registered manager took action when they considered that a person's needs could not be met at the home. They worked with social care professionals to ensure that any person leaving the home received appropriate support.

On the first day of our inspection we did not see any activities taking place. There was very little interaction between staff and people who used the service unless it was to attend to personal care needs. We observed that in one half hour period three people received only one brief interaction from a staff member despite them being alert and responsive.

On the second day a member of staff was on duty specifically to arrange activities. We noticed a considerable difference in people, including the people we had observed the previous day. People were interacting, talking and taking part. The provider told us that they were currently in the process of appointing a dedicated activities coordinator. Staff consulted people about how they would like to be supported, where they would like to sit and if they would like to join in in group activities. People's decisions were respected and supported. When people were seen to change their minds staff accommodated this without question. For example one person wanted to do an activity and then they decided they wanted to go to their room.

Care plans gave a description of the person's care and support needs from the person's perspective. These plans were reviewed regularly and reflected people's changing needs'. Staff told us how care plans were useful documents and that important information was also handed over verbally to ensure they had information available as soon as people's needs changed. Staff referred to daily records to check that people were having enough to eat and drink. When records showed that people were not drinking enough to maintain their good health we heard staff offer more drinks to them. They also referred concerns to senior staff to ensure that people's needs were referred to health professionals if required.

People told us that they would speak with the registered manager or the nurse on duty if they had any complaints. We saw how people who used the service were happy to approach the manager and the staff to discuss all aspects of their care and support. Relatives also told us that they had regular opportunities to speak with the registered manager and would be confident to raise any concerns that they might have with them. People told us that they were confident that resolutions would be found informally without having to use the formal processes. The complaints procedure was displayed in the entrance hall making it readily accessible. Staff told us that they were aware of the complaints procedure and they would share it with people who used the service if necessary. Records showed that the registered manager had not received any recent complaints.

Good

Is the service well-led?

Our findings

At the time of our inspection in July 2014 we found that more robust auditing systems were required to monitor and assess the quality of the service provided. At this inspection we found that improvements had been made in this area. The registered manager and providers were proactive in overseeing the management of the home. They have developed a robust system to regularly assess and monitor the quality of service. They had created an atmosphere where people felt able to approach them informally to share their views and comments. People told us that the registered manager was 'approachable'. We saw the registered manager and the providers interact positively with people who used the service.

We saw that regular audits had been completed by the registered manager and also by the providers. Audits were carried out in the areas of infection control, care records, medication, health and safety and catering. Action plans were in place where required to address any identified issues. For example, the provider had identified issues with the recording of medicine totals. They had implemented a check sheet to address this. The registered manager had then identified that staff were not completing this as required. Both the registered manager and the provider told us how they were now taking more robust action to ensure procedures were followed. This showed that they were reviewing processes, making changes and then monitoring their implementation to ensure improvements took place to practice.

We saw that all conditions of registration with the CQC were being met and notifications were being sent to the CQC where appropriate.

We looked at the processes in place for responding to incidents and accidents. We saw that incident and accident forms were completed and although not always signed off by the registered manager we could see how actions had been taken to make changes to prevent reoccurrences. The number of accident and incidents had reduced over recent months suggesting arrangements were working.

We spoke with the registered manager of the home and they understood their roles and responsibilities. They told us how they had worked closely with the providers to make improvements to the service. They told us they received, "Excellent support" and that the home had, "Moved on in leaps and bounds."

Staff told us that the providers and the registered manager made them feel valued and they felt that they could approach them with their views about how to improve the service and they would listen and take action if needed. Staff said that they felt consulted and that their feedback was used to make the service more effective. For example they had looked at information sharing within the home and this has had a positive impact. One staff member told us, "We've recently changed handover so now all the staff are involved. We have a list of everyone and what's changed. It's useful." Another staff member told us, "It's getting better; it was a good move that everyone is involved at handover."

Health professionals told us that named senior staff, including the registered manager had been, "Instrumental in turning the place around." They told us that they were confident in the registered manager's ability to lead the home. A relative told us that they visited the home unannounced when looking for a suitable home for their relative. They told us, "I dropped in unannounced and everything was shown to me. Everything was open."

The registered manager demonstrated that they were aware of the issues that faced the home. They told us, and showed us, how they were responding to improve the service provided. For example, changes were being made to improve the environment. Staffing levels had been increased and work was taking place to ensure that the culture of the home reflected the new provider's aims and objectives to provide quality care.

The providers and the registered manager told us that resources were available to enable them to make changes and improvements. The budget had been reviewed and increased for food and staff told us that more appropriate equipment had also being purchased to enable them to support people more comfortably. For example, new chairs, beds and cushions had been provided to improve the quality of the service provided.

A health professional told us that there had been a, "Massive improvement" within the home. They told us that the home was accessing equipment and recourses to ensure they could meet people's assessed needs. They also

Good

Is the service well-led?

gave us a positive example of how the home had worked with outside agencies to access training and support to enable them to respond to the changing and challenging needs of a person that they had supported.

We saw that the registered manager and the providers sought the views and opinions of people who used the service and their representatives. People and their relatives told us that when they had shared their views about the service they felt listened to by the registered manager. We saw that residents' meetings took place as did relatives' meetings. The registered manager told us how they tried to make these social events demonstrating how important people's views were to them.

We saw minutes of meetings that detailed changes and improvements made and agreed. We also saw how the providers asked people to say how well the home was meeting people's needs. We saw how they had identified that there had been issues in relation to the quality of the care provided and had been working with the registered manager to make improvements. The providers demonstrated to us that, when they had identified issues actions were taken to ensure they were addressed. As a result the quality of the service had improved.