Care Quality Commission

Ashbrook House Limited

Ashbrook House

Inspection report

20 St Helier Avenue
SM4 6LF
Tel: 020 8646 3096
Website: www.example.com

Date of inspection visit: 13 January 2015
Date of publication: 16/03/2015

Ratings

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

Overall summary

The inspection took place on the 13 January 2015 and was unannounced. We last inspected the service on 17 April 2014 and there were no breaches of legal requirements at the last inspection

Ashbrook House is a care home that provides support and care for up to nine people who have a learning disability and/or a physical disability. At the time of our inspection, there were five people living at Ashbrook House.

According to its conditions of registration the service is required to have a registered manager in post, but did not have one. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

We talked with the acting manager about not being registered since May 2014 and he told us the provider was considering some structural changes to the organisation before an application would be made. This however remains a breach of the conditions of the provider's

Summary of findings

registration. We are following this up separately with the provider and will take action where required so they make the necessary arrangements to ensure the service has a registered manager in post as soon as possible.

The provider had systems in place to keep people safe. Individual risks had been assessed and their care was planned in a way to minimise the possibility of harm. People received their medicines safely and when they needed them. Staffing levels were determined according to needs of the people who used the service and were adequate during the inspection. Only suitable staff were recruited by the provider in this way risks to people were reduced.

People who used the service had their needs assessed and met. The staff had a good understanding about people's individual needs and knew how to care for them. There was clear information about each person and the support the staff needed to offer. People had the opportunity to participate in social and recreational activities dependent upon their interests and preferences.

The provider had policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS is a way of making sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

People had access to the healthcare services they needed. Their nutritional needs were met. People lived in a safe and well maintained environment.

The staff were supported to understand their roles and responsibilities. They had the training they needed and took part in regular team and individual meetings. There were suitable systems to monitor the quality of the service and to obtain feedback from the people living there, their representatives and other stakeholders.

We observed staff were kind and caring; they had positive relationships with the people they cared for. Staff maintained people's privacy and dignity when providing care and support to people.

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?

Good

The service was safe. People and their relatives told us they felt safe. Staff knew what to do if they felt people were not being cared for properly.

Recruitment checks were completed on staff so that the provider was making sure only appropriate people were employed. There were enough staff on duty to meet people's needs.

People were supported to have the medicines they needed according to the way these were prescribed.

There was learning from accidents and incidents.

Is the service effective?

Good

The service was effective. Staff received training and support so they could do their jobs effectively.

People were supported to stay healthy and to access healthcare services they needed. This included receiving nutritious meals.

The provider had policies and procedures in place in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had received training and were aware of their responsibilities in relation to the Act.

Is the service caring?

Good

The service was caring. People told us that the staff were kind and caring. We saw staff knew people's preferences and interacted with them in an attentive and compassionate manner.

Staff treated people with dignity and respect as well as promoting their independence.

People were involved in making decisions about their care and support they received.

Is the service responsive?

Good

The service was responsive. People's needs were assessed. Care plans were in place outlining people's individualised care needs and these care plans were continually monitored so they reflected current needs.

People had opportunities to be involved in a range of activities reflecting their interests.

People were encouraged to say what they thought of the service, and they felt their views would be listened to.

Summary of findings

Is the service well-led?

The service did not have a registered manager in post, despite being required to have one.

The acting manager was open and approachable. People who used the service and staff said there was good two way communication and that they felt able to raise any issues of concerns they had.

There were robust quality monitoring systems in place that the acting manager and provider followed.

Requires Improvement 

Ashbrook House

Detailed findings

Background to this inspection

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

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

The inspection was conducted by a single inspector. Before the inspection we reviewed information about the provider, including the last inspection report and notifications the provider had made to us about significant events at the service.

At this inspection we met three of the five people who lived at the home. We spoke with two members of staff and the acting manager. We observed how people were being cared for and treated. We looked at how medicines were managed. We viewed records relating to people's care and treatment, including two care plans. We also viewed records of staff training and the recruitment information for two members of staff, records of meetings held at the home and checks on quality and health and safety.

After the inspection, we also made contact with two people's relatives for their views about the service and two professionals who had regular contact with service.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. A relative of someone using the service when asked if they felt the service was safe, said "I wish everyone could be looked after as well as my [relative] is at Ashbrook."

The provider had procedures in place to help protect people from avoidable harm and staff were aware of them. We spoke with staff on duty and they were able to tell us what they would do if they suspected someone was being abused or at risk of abuse. Staff had received recent training in safeguarding adults and this was repeated annually. Notifications we had received from the service showed the provider had taken appropriate action when there had been allegations of abuse. They had notified the relevant authorities and undertaken investigations when requested to do so.

The service followed safe recruitment practices. We spoke with one member of staff about their recent recruitment and they told us about the process and all the checks that had been undertaken. We saw each staff file contained a checklist which identified the pre-employment checks the provider had carried out. These included two references, proofs of identity, a completed application form with full employment history and an up to date criminal records check.

We looked at care plans which showed the service had completed comprehensive assessments of risk for individuals and for the service. They had identified where people were at risk and how people needed to be supported so that they were safe and supported to maintain their independence. For example, there were assessments for people who were administering their own medicines and for the use of facilities in the local community. We looked at a sample of risk assessments. These were clear, up to date and the staff told us they were aware of the content.

We checked the staff duty rotas and saw there were sufficient staff on duty to keep people safe and meet their needs. The acting manager told us they had a flexible approach to arranging staffing levels and would regularly ensure additional staff were on duty if there were extra activities people were involved in. The acting manager also told us staffing levels were regularly reviewed and adjusted according to the needs of people who used the service at any given time.

We looked at the management of medicines to make sure people received them as and when they should. We saw medicines were stored appropriately in a locked cabinet secured to the wall. For everyone in the service we saw that their medicines information had a photograph and a list of allergies so the risk of errors occurring were minimised. We checked people's medication administration records (MAR) and saw there were no omissions for the primary member of staff administering. However, we noted the provider's internal policy stated that two members of staff should sign for administering medicines and this had not been undertaken on a recent day. We discussed this with the acting manager, who agreed to raise the issue with the provider about the necessity of two members of staff being required to sign for medicines.

All staff had received medicines training within the last year and their competency to administer medicines was regularly assessed. The acting manager audited medicines on a weekly basis. We also saw that an external pharmacist visited the home once every six months to audit the medicines administration. Any recommendations made had been acted on by the provider.

Accidents and incidents were recorded in a way that would allow for analysis. Staff confirmed there were regular discussions in team meetings so any incidents could be discussed to prevent it occurring again.

Good

Is the service effective?

Our findings

Staff told us there was a range of training opportunities available to them and these were regularly updated. A member of staff said, "There's lots of training here – either e-learning or classroom based." Records we looked at showed that training undertaken included manual handling, safeguarding adults and medicines management. The acting manager showed us a computer record which centrally logged all the staff training undertaken and when there was a requirement for it to be refreshed.

We talked with a relatively new member of staff who told about their induction into the home. They told us initially they spent time reading policies and procedures and then shadowing experienced staff. They said they were given support from the manager and staff team so they became familiar with people living at the home and their needs.

Where people were able, they had given consent to their care and treatment. We saw the staff offered people choices and allowed them to make a decision about specific care tasks and what they chose to do. For example, we heard a member of staff ask someone what they wanted for breakfast; The person was unclear, we then heard the member of staff say, "come and show me what you want" and then take them into the kitchen.

We saw that people who had restricted mobility or used a wheelchair were able to move around freely on the ground floor. People who were more mobile had their bedrooms on the first floor. We saw that some other adaptions had been made for people in wheelchairs so they could achieve greater independence. There were also adapted bathrooms and hoists for people who needed them.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We spoke with the acting manager who understood their responsibility for making sure people's liberty was not unduly restricted. The service had initiated a visit from the local authority lead on assessing people under the Mental Capacity Act 2005 to review whether people at the home were being deprived of their liberty and if applications for authorisation were required. The assessor had recommended that no urgent applications for DoLS were required but had advised that applications should be made for everyone living at the home. The home was in the process of completing these applications. In the interim we saw staff had undertaken training regarding the Mental Capacity Act 2005 and they were able to demonstrate a basic understanding of their responsibilities under the Act. There were also reminders on notice boards of the principles of capacity and what staff needed to do to ensure so they remained within the law.

People's nutritional needs had been assessed and monitored. They were weighed monthly and where necessary people were under the care of a dietitian or speech and language therapist. The weekly menu was decided in general by people who used the service. One person told us, "It's chicken curry tonight – we just tell them [the staff] what we want to eat." Someone else told us, "The cooking here is very good." We saw that people were offered and assisted to make hot or cold drinks whenever they wanted to. There was fresh fruit readily available. People told us, that if they didn't like what was on offer to eat or had changed their minds, then staff were very willing to provide something else.

People's health needs had been assessed and recorded in care plans. Each appointment with a healthcare professional had been recorded with actions for staff to follow if required. There was written information from healthcare professionals which gave advice about caring for people. Staff told us that professionals would sometimes come to service and offer training sessions. One professional we spoke with said, "You can't fault the home and the way they work with us".

Good

Is the service caring?

Our findings

People using the service and their relatives told us they were happy with the level of care and support provided at the home. They said staff were kind and caring. One person using the service told us, "I like it here, the staff are very good to me." A relative told us "General care is excellent". We observed staff always interacted with people in an attentive and compassionate way. For example when sitting with people during lunch, they assisted when necessary, talking to people throughout so they would feel comfortable and relaxed.

Staff respected people's privacy and dignity. We saw staff knocked on all doors before entering. If they were providing personal care, the door was always kept closed. We saw someone being moved from the bathroom to their bedroom, they were entirely covered up to maintain their privacy and dignity. Where people had expressed a preference for specific gender care, this was respected.

We looked at care plans and saw they were written in a way that centred on the person as an individual. They contained information about people's backgrounds, their interests and preferences. There was a focus on people's strengths and what they could do for themselves for example one person was able to make light meals for themselves. If people did require support it outlined how it should be given so that people's independence was maintained, so for example, one person could vacuum their bedroom if staff moved all the furniture.

The staff had a good understanding of people's diverse needs. These were recorded in care plans and people were supported to eat culturally appropriate diets and visit places of worship when they wanted to. Staff knew about people's preferences and could respond accordingly, for example how someone liked their tea. Staff were able to tell us about the people they were caring for and what their future aspirations were.

Some people were unable to communicate verbally. We saw staff took time to observe people's responses and respond accordingly. There were detailed care plans about each person's communication needs and how they expressed their choices and consent. Where people were able to they had signed their own care plans as a way confirming their agreement with them.

We saw there was a wide range of information for people living at the home and their visitors. Information was displayed in the communal areas of the hallway and dining area. There was a reminder about the 'Important Things for us at Home', the principles of the Mental Capacity Act and a visual timetable for some people who used the service. The complaints policy was also readily available for visitors and for people who used the service in a format they would be able to access. We saw evidence that all people were registered to vote and it was then their option whether to do so or not.

Good

Is the service responsive?

Our findings

Each person had an individual plan of social, educational and recreational activities based on their preferences and interests. One person told us they had asked staff if they could do more activities and the staff had responded with, “ok, not a problem, what do you want to do?” Another example of individual choice was one person attended a cookery class at a day centre whilst someone else attended art class at college. There was also a range of community outings which were planned according to people’s expressed wishes. Some of these were planned and other spontaneous for example visits to the pub, local shops or garden centre. On arrival at the service, one person was attending a day centre with a member of staff, three people were on an outing in the community and one person had decided to have a relaxed morning and was still in bed.

People told us they could make choices about their own care, how they spent their time and their environment. People told us it was up to them if they wanted to go out or take part in a particular activity. One person told us how they had made the decision where to go on holiday during the summer months. They also told us how they had chosen the colour for their bedroom and all the soft furnishings; and now wanted to change the layout of their bedroom and had talked to the acting manager about it.

People who used the service and their relatives said they were regularly involved in reviewing the care received. They were invited to attend care plan reviews and relatives told us they were immediately informed if there were any changes. The written care plan was updated after every review and people who attended were invited to sign the document. In this way the care plan reflected people’s current needs and future wishes.

The service had a complaints procedure and this was provided in pictorial and easy read formats for people living at the home. There was an additional version for other people who may come into contact with the service. We were shown a record of all complaints and how these had been investigated and responded to. There was evidence of learning from complaints and concerns. We saw that people within the service regularly arranged and held their own ‘residents’ meetings. The acting manager told us people would bring issues to him about the service and he would respond accordingly. We saw the minutes of the meetings which showed that this did take place. People who used the service also had opportunities to express their views through regular meetings with their key workers (key workers are staff who have a particular responsibility to shape the care for an individual within the home).

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post although it is required by law to have one. The last registered manager left in May 2014. The acting manager told us the provider was considering some structural changes to the organisation before an application would be made.

The provider was therefore breaching its conditions of registration. We are following this up separately with the provider and will take action where required so they make the necessary arrangements to ensure the service has a registered manager in post as soon as possible.

The acting manager had previously been the deputy at the service and was well known to people who use the service, their representatives and other professionals. Everyone we spoke with told us he was approachable and open. People knew their views would be listened to and acted upon. We spoke with one person who said, “He [the acting manager] listens to what we’ve got to say”.

The acting manager worked alongside the staff team providing care and support to people living at the home. In this way he was aware of issues relating to the care of people who used the service. Additionally the acting manager was getting first-hand knowledge of how the staff team at Ashbrook House worked.

With regards to monitoring the quality of the service the acting manager was continuously monitoring and taking immediate action when necessary. A regional manager visited the home unannounced on a monthly basis and we saw records that confirmed this. The regional manager’s purpose was to check the quality of the service. The providers operational head office also conducted regular audits and checks on different areas of the service. An action plan was created which then identified areas for improvements. This document was shared with the acting manager who was given timescales to respond to the issues and rectify if there were any problems.

The service sent out satisfaction surveys to people who lived in the home, their representatives and other professionals. This was done on an annual basis. The service was in the process of completing the survey for this year and had already sent out and received comments back from people who used the service and staff. All the responses they had received were positive. Professionals had also recently been approached for their views of the service.

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.

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.