Sanctuary Care Limited

Ashdale Lodge Residential Care Home

Inspection report

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22 November 2017

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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

Summary of findings

Overall summary

Ashdale Lodge Residential Care Home is registered to provide care and accommodation for 37 people, some of whom may be living with dementia. The service has four communal lounge areas, some of which are designated as quiet areas, a dining room, conservatory and a garden. Bedrooms are mainly for single occupancy but there are three shared rooms for couples or people who wish to share. The service is situated about a mile west of Hull City Centre and is close to a range of community facilities. It is on major bus routes and has a small carpark.

At the last inspection on 19 October 2015, the service was rated Good. At this inspection, we found the service remained Good. This inspection took place on 13 and 22 November 2017 and was unannounced.

At the time of our inspection, 30 people were using the service and there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found best interest meetings did not always include all relevant people and did not always consider least restrictive options. We have made a recommendation for the provider to use the Mental Capacity Act 2005 code of practice to inform their policies and procedures regarding best interest decision-making.

People told us they felt safe living at the service. Staff were clear about their responsibilities to protect people from the risk of harm and abuse, and had completed training in safeguarding vulnerable people.

People received their medications as prescribed. However, the provider had recently identified issues in the recording of medicines and had put steps in place to reduce the reoccurrence of this.

People's nutrition and health needs were met. Referrals to healthcare professionals were completed in a timely manner and people were involved in making decisions regarding their own treatment and care where possible.

Although some care plans were not fully up-to-date, staff were responsive to people's needs and we found no detrimental impact on people. Pre-admission assessments enabled staff to provide care for people from the day of their admission and assessments were person-centred.

We found staff were recruited safely and received an induction, which was linked to the Care Certificate. Staff received training, supervision and appraisal as required, and there were sufficient staff on duty to meet people's individual needs. Staff were trained in infection control and the service was safe, clean and tidy. Business continuity plans and personal emergency evacuation plans (PEEPs) gave staff clear guidance on how to keep people safe in the event of emergencies.

The environment supported people who were living with dementia and catered for people's individual needs. We saw the décor, activities and many communal areas enabled people to spend time as they wished. Activities were tailored to people's needs and preferences. Newsletters kept people updated with relevant information.

We found people were supported by staff who were caring, patient and compassionate. People were treated with dignity and respect, and were enabled to be independent. There were no restrictions on visits, and accessing the community was encouraged. Local community groups, such as schools, were invited to the service and there had been a recent open day where the community could attend the service.

We found the culture of the provider to be open and inclusive. Comments regarding the provider and registered manager were positive, and everyone said that they were approachable. People told us any complaints would be addressed and we saw the provider had responded to feedback. The registered manager understood and fulfilled their duty to report notifiable incidents to the Care Quality Commission as required under legislation. The provider had developed quality assurance and governance systems to highlight shortfalls and drive improvements within the service.

Further information is in the detailed findings below.

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 remained safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not always included people's relatives in best interest decisions and did not always consider least restrictive options. We have made a recommendation about the provider using the Mental Capacity Act 2005 code of practice to inform their policies and procedures.

People's health and nutritional needs were met. Healthcare professionals were consulted in a timely manner. Diets were catered for, and people could eat with their family in private if they wanted.

Staff had good knowledge and skills in how to meet people's needs and received regular training.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service remained well-led.

Ashdale Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 and 22 November 2017 and was unannounced.

Two Adult Social Care Inspectors and an expert-by-experience undertook the inspection. 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 expertise of older people living with dementia.

Prior to the inspection, we contacted the local authority commissioners and safeguarding team to gain their views about the service. We looked at notifications that the provider had submitted to the Care Quality Commission (CQC). Notifications are forms, which the provider has to submit to us by law. They tell us how the provider manages incidents and accidents for people in their care. We also looked at the Enter and View report completed by Healthwatch. The Enter and View report identifies areas of good practice and makes recommendations for improvements.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we talked with four people who used the service and five relatives. We also spoke with the regional manager, the registered manager and four members of staff.

We looked at five people's care records and six medication administration records (MARs). We also 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. We observed how staff interacted with people in the communal areas of the service and we completed a tour of the building.

We reviewed how the service used the Mental Capacity Act 2005, to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held to make important decisions on their behalf.

We saw documentation and records relating to the day-to-day running and management of the service. These included the recruitment information for three members of staff and five supervision and appraisal records. We viewed staff induction and training documentation and staffing rotas. We also looked at the certificates for maintaining equipment, the business continuity plan, and policies and procedures.

After the inspection, we asked the provider to send us further information about the vision and values of the organisation, the statement of purpose and updated behaviour management care plans. This information was received by the requested time, which helped us to make a judgement about the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "I definitely feel safe; very much so" and "I do feel safe living here, quite safe." Relatives said, "I feel they're absolutely safe living here; I've never actually seen anything that concerned me" and "I'm sure they're safe living here, totally."

We found people were protected from potential harm and abuse. We saw safeguarding policies and procedures were displayed in the service and staff were clear in their responsibilities to report any concerns. They had received training in safeguarding vulnerable people from abuse and they told us, "I'd tell the senior and [Name of registered manager]" and "People can't complain for themselves; care staff or the manager has to do it on their behalf." We found staff were knowledgeable about the forms of abuse and the signs that may indicate someone was experiencing neglect or being mistreated.

People had individual risk assessments in place so staff were aware of the steps to take to keep people safe. For example, we saw one person had a risk assessment to reduce the risk of developing pressure sores. A relative told us, "They would happily sit, but staff keep an eye on them and constantly monitor them." We looked at the accident and incident records and analysis, and saw there were few incidents. Records showed referrals were made to professionals as required, and records had been updated.

Medicines were stored securely and people received them as prescribed. One person said, "I get it on time every day." We saw audits had identified issues with the recording of medicines. These issues were being addressed internally and the regional manager told us of the steps they had taken to reduce the likelihood of similar errors occurring again. We looked at people's medication administration records (MARs) and medicine stock levels. We found these tallied and medicines were well-documented.

We found there were sufficient staff to meet people's needs. People told us, "I think there are enough staff." A relative said, "There does seem to be enough staff; I have never not been able to talk to or access a staff member and I have been many times of the day."

We saw staff were recruited safely and all pre-employment checks were completed as required. Written references were received, and Disclosure and Barring Service (DBS) checks were in place, before they started work. The DBS helps employers to make safer recruitment decisions and prevents unsuitable people from working in the care industry.

We found the service was clean and tidy. Staff were trained in infection control and procedures were in place to stop the spread of infections. Staff told us there was sufficient personal protective equipment and we saw clear directions in the laundry for staff to follow.

We found the premises were safe and met people's needs. One person told us, "It's very nice here." Relatives said, "I've never noticed any problems" and "I have never seen anything that concerns me." We observed the garden was secure and people were able to access all communal areas independently. This meant people were able to choose where to spend their time. We saw lights automatically illuminated in the corridors to

promote safety, and there were staff competent in first aid on every shift.

There were business continuity plans in place, which gave clear guidance to staff on how to keep people safe in emergencies such as utility failures or fire. Personal emergency evacuation plans (PEEPs) and emergency hospital admission sheets, gave relevant details to enable people's needs to be met in emergencies. We found maintenance checks were completed as required, including call bells, the lift, electrical equipment and hot water outlets.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff knew how to gain consent prior to care tasks, and mental capacity assessments and best interest meetings had taken place as required. However, the best interest meetings did not always consider and record least restrictive options and did not always involve all relevant people. For example, we saw best interest decisions had been taken solely by senior care staff and did not involve people's relatives. A member of staff told us, "Seniors make the decisions with psychiatrists." Not involving people and their relatives meant choice and decision-making could be limited. We also saw best interest decisions had been made by other agencies and the provider had not assured themselves this was the least restrictive option. We spoke with the regional manager and the registered manager, and were assured this would be addressed immediately. They also told us they would make sure the policies and procedures were adjusted to support more inclusive practice.

We recommend the provider uses the MCA code of practice to inform their policy and procedures regarding best interest decision-making. This will ensure best practice is undertaken by the registered manager and staff.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had submitted 20 DoLS applications, and notifications as required, for people who used the service.

People told us their healthcare needs were met and they were treated as individuals. One person said, "If I want to get in touch with my doctor, I would do it myself," whereas another person said, "If I wanted to talk to my doctor, the home does it for me." We found healthcare professionals were consulted as appropriate and referrals were made in a timely manner. A relative said, "I'm involved with making decisions and regarding their health." The relative also said staff kept them informed about health issues.

We found people's dietary needs were met. People who used the service told us, "The food is very good; I don't leave much", "I always enjoy it" and "The food is good but the plates are cold." We mentioned this last point to the registered manager to address. Relatives told us, "I had a fish and chip lunch here once and it was delicious", "The food is gorgeous and it looks stunning; I definitely would go for it", "I've heard it's a good menu" and "The food looks good to me." We saw the food looked healthy, appetising and dietary needs were catered for. Staff told us, "We cater for textured diets; presentation and colours are important. It

has to look good" and "Special diets are well-catered for; the food's pretty good." We also saw people and their relatives could request to have a private meal or coffee together, if they wished to spend time alone as a family. The service had a Food Hygiene Rating Scheme (FHRS) score of five. This is the highest score possible. The FHRS shows people the standard of food hygiene in the service.

We saw assessments of people's needs had taken place prior to their date of admission. Staff told us this ensured people's needs could be met on their admission date. We also saw there was a 'settling-in checklist' to enable the transition between services to be as smooth as possible for the person. Staff told us that all people who used the service were given an information guide. This welcomed the person to the service, detailed the provider's values and gave relevant information such as menus, transport and health and safety. They said that this enabled people to become accustomed to their new environment as quickly as possible.

We found staff skill and knowledge was good. Records showed staff had completed a thorough induction, which was linked to the Care Certificate. The Care Certificate is a set of national minimum standards that health and social care workers should work to. Staff were also competency assessed prior to working alone; they completed an induction booklet to test their learning and embedded their knowledge through practice. This booklet was checked and signed by senior staff.

Staff had completed a range of training relevant to caring for people. This included dementia in care, dignity in action, nutrition, MCA and DoLS, moving and handling, first aid, fire safety and safeguarding. Reminders were sent to staff when further training required completing and a member of staff told us additional courses were sometimes offered. They said, "I've got a couple of courses next month, in-house ones on challenging behaviour." This meant staff knowledge and skills were regularly updated. We saw care competencies were assessed. This meant the provider could be assured staff were competent in their role. In addition to required training courses for their own job role, domestic staff could access similar training to care staff. They told us, "The training is unbelievably good. Management like everybody to be qualified." This meant all staff had an awareness of dementia and dignity regardless of their role.

We found staff received one-to-one supervision and appraisal as required. Staff told us they received extra support if they needed it, for example, when in their induction period. Staff said, "With one-to-ones, some people get them every three months then every six months after probation" and "Mine [one-to-one supervision meetings] are every six months; appraisal is yearly." We saw the supervision contract said that supervisions should be every six to eight weeks and we found that staff received some form of supervision more frequently than the formal one-to-one sessions. For example, competency checks were carried out. This meant staff received different methods of support and the provider could be assured staff were competent in their work.

We saw the provider had adapted the environment to meet the needs of the people living in the service. People's rooms were personalised and we saw memory boxes were in place to aid people with dementia to find their room. We saw many bedroom doors were brightly coloured. The registered manager explained there were plans to redecorate the remaining doors, so all would be painted in the preferred colour of the person living in the room. We observed the communal areas supported people's preferences, for example, there were several designated quiet areas and two communal spaces for activities. This meant people could choose how to spend their time and could also have some space if required. This follows best practice guidance by the Social Care Institute for Excellence (SCIE).

Good

Is the service caring?

Our findings

People told us the staff were caring. They said, "The staff care about me, I'm convinced they do", "The staff are very nice", "The staff are very, very good" and "They are great; I couldn't wish for anybody better." Relatives told us, "I do think they care about them; I have nothing bad to say about the staff", "I'm sure they care; they're always very attentive" and "The staff really care about them."

We saw staff treated people with patience and kindness, and involved them in their care. For example, we saw they ensured one person completed a task they wanted to do, despite the repetition required to enable this. They supported the person in a calm, patient and re-assuring manner. People told us staff developed supportive, caring, professional relationships with them. They said, "If it wasn't for the carers, I would be lost" and "I don't have any concerns about any of the staff; no problems." Relatives told us, "I don't think myself and [Name of relative] would have got through it without their help and support" and "The staff are brilliant here."

We found people's privacy and dignity were maintained by staff. A relative told us, "They are absolutely respectful of privacy and dignity." Staff said, "I always listen to what people want, and treat them with respect" and "I cover people up, speak to people and knock on their doors [before entering]." We saw noted in people's care records, staff had maintained people's dignity by covering them with a dressing gown or towel when required.

There were no restrictions on visits and people told us they were enabled to maintain effective relationships with their family. They said, "My visitors are always made to feel welcome; they get tea and biscuits" and "My relatives come to visit me and they are made very welcome." All relatives spoken with told us they could visit any time they wanted.

We saw communication plans were in place for people. These detailed relevant aspects of a person's life history, their strengths and their communication needs. They enabled staff to talk to people about their past and meant people received support from staff who were aware of their individual communication preferences and needs. Relatives of people who used the service told us, "[Name of person who used the service] has a wicked sense of humour and they have a great relationship [with staff]" and "Staff seem to understand their needs but they have dementia and are in need of quite a lot of help." Throughout our inspection, we saw staff communicated effectively with people and encouraged them to express their opinions.

We observed staff showed compassion and consideration to people and their circumstances. Staff told us, "I try to do my best to meet their needs" and "It's their home." We saw assessments noted people's interests, cultural and spiritual needs. Staff said, "We have church services." The registered manager said they catered for people's identified individual equality and diversity needs.

People told us they could be as independent as they wanted. They said, "I decide what I want to do every day" and "I communicate with my family on the outside; I have a mobile phone." Relatives of people who

used the service told us, "[Name] tries to be independent and the staff help them to feel that way" and "They do support them to be as independent as possible but they need a lot of help."

Staff were aware of the need to maintain confidentiality. We found records were stored securely; computers were protected by passwords. This meant only authorised staff could access the system.

Good

Is the service responsive?

Our findings

We found staff were responsive to people's needs. People had assessments of their needs completed and care records contained their life history, preferences and cultural choices. We found care plans were person-centred, although some care plans were not fully up-to-date. We spoke with the registered manager and they said they would ensure these were updated immediately. After the inspection, we received copies of the updated care plans.

People who used the service and their family told us they were involved in discussions about their care. Relatives said, "If there are any decisions to be made about their health and welfare, even down to when they have the flu jab, it's discussed with either me, [Name of another relative], or both of us" and " [Name], myself and the social worker were all involved in setting up the care plan." This meant the service was inclusive of people's family and people had choices in the care they received. However, we saw these discussions were not documented in people's care records. We spoke with the registered manager about this, and we were assured in future, these discussions would be documented. People were treated as individuals and staff catered for their preferences. Relatives told us, "They know their likes and dislikes" and "They definitely do treat people as individuals."

There were activities taking place during our inspection, and there was a pictorial display showing which activities were planned for the week. People could independently access musical equipment and other activities, such as books and games, in the lounge areas at any time. We observed there were large print books available for people to read. This meant people could read more easily if their eyesight was failing.

People told us they could participate in the organised events if they wished. One person said, "I do have choices of what to do." Relatives commented, "[Name] regularly attends activities. I have been here and joined in with them on occasions", "They do attend group activities and enjoy being a part of the community here" and "They do join in and watch the activities far more than I thought they would; they are obviously being encouraged." We found activities were tailored to people's individual preferences and everyone was asked if they would like to participate.

Staff told us they encouraged people to attend group activities but they also went to people's rooms to talk or do individual activities, if they preferred this. They said this meant people received social contact to suit their needs. Relatives told us, "Staff support as much as they can; [Name] is immobile but they move them in a wheelchair as they like to be in the lounge." Staff explained people's individual needs were documented in their records and they updated these as necessary. One member of staff informed us, "There's a planner on each resident's door for their particular interests and requirements." We saw care records had been updated to reflect a person's request not be informed of some activities.

We observed the complaints, compliments and comments process was displayed in the service. People told us they knew how to complain but had few reasons to. They said, "I would tell the staff", "If I wish to complain I would speak to the manager; I have never had any problems" and "I've been here just over a year and no problems at all." Relatives of people who used the service told us they were unsure of the complaints

procedure, but they would complain by speaking to the manager if they needed to. They said, "I don't know how to complain; I would contact the manager", and "I have never had any need to complain but if I did, I would ring the manager." One relative told us, "We did have one incident where a resident was very aggressive which was sorted immediately." This showed the provider responded to complaints in a timely manner. Staff told us they were certain complaints would be addressed and commented, "They've taken complaints seriously in the past." We found complaints were responded to in a timely way. The system was computerised, so they were easily cross-referenced and analysed to see if there were any patterns or trends. The regional manager told us this data would then be used to develop the service.

Good

Is the service well-led?

Our findings

We found the culture within the service was open and inclusive. The values of the provider were clear and set out pledges from employees and the service as to the care people could expect to receive. The comments we received regarding the management of the service were positive. People told us the registered manager was approachable and accessible. They said, "My opinion of the management is they are very good" and "I reckon I could approach the management at any time." Relatives said, "They [registered manager] are lovely; they are approachable" and "My relationship with the staff and management is excellent; I feel I can knock on their door at any time." A member of staff told us, "They're [registered manager] understanding and do a lot for the residents; they're approachable." The registered manager had remained the same since the last inspection and was aware of, and fulfilled, their responsibilities to report incidents and other notifiable events.

We found people did not usually have any problems or concerns. Relatives told us, "I've been coming for three years and never had any problems", "It seems to run really smoothly" and "It runs fine; I have never known any serious problems." We found the provider listened and responded to feedback. Relatives told us, "Occasionally when they need something, I relay this to the manager and they attend to the matter" and "We would like to know what's on the menu but there aren't any menus on the tables these days. I have raised that point." During our inspection, we noticed menus were available. This meant the provider had responded to the feedback.

Relatives told us, "I am totally satisfied with the level of communication between the management to myself; we know everything that's going on", "I know they have relative's meetings" and "We have not attended any relative meetings but we are in constant touch." We saw a newsletter actively encouraged people and their relatives to put forward ideas or suggestions, and to attend the 'resident's meeting'. In addition, there was a monthly activities newsletter, which aimed to share innovative stories and best practice amongst the provider's services. We saw this service had received recognition for enabling the environment to meet the needs of people who lived there. There was also a quarterly newsletter for staff and managers. This gave best practice advice and enabled them to keep their knowledge up-to-date.

Staff told us the provider encouraged links with the local community. They said, "We have two local primary schools that send parties of children in. Also, we recently had an open day with fish and chips for lunch and invited the local community to join us" and "[Registered manager's name] invites the community in and relatives can eat with their family." People told us that they were not socially isolated but felt a part of the community. We saw relatives were encouraged to take their family to visit local amenities and people had been taken to community events. The service had also won Hull-City Council awards for their gardens for the previous two years.

The registered manager completed regular audits on areas such as medication, infection control, care records and fire equipment. These were overseen by the provider which meant they could be assured issues were identified and actions taken. The audits monitored the quality of services provided to people and gave actions for improvement. We found actions identified in previous audits had been completed. The quality

monitoring systems used were mainly electronic, which meant any concerns were highlighted and accessible to staff so actions could be taken. For example, people's body weights were monitored and the system clearly showed any increase or decrease in weight so staff could seek dietetic advice quickly. The regional manager told us this enabled issues to be identified and action taken. We saw the provider ensured every person's care record was reviewed at least annually, giving feedback to staff on where to improve.

The registered manager informed us medication errors were crossed-referenced by using the computer system, and this information was used in the audits to ensure a comprehensive analysis. We discussed with the registered manager and regional manager the actions they had taken to address internally identified medication errors and saw the analysis was being used to drive improvements in the service.

There was a nomination scheme where people and relatives could nominate staff to receive recognition for going 'above and beyond.' The regional manager told us this aimed to increase the quality of care for people but also motivated staff.