Bupa Care Homes (BNH) Limited

Ashley House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection of Ashley House Care Home commenced on 1 August 2017 and was unannounced.

We undertook this focused inspection of Ashley House Care Home on 1 August 2017. This inspection was prompted in part by the provider's notification to CQC of a significant event. The information shared with CQC about the incident indicated potential concerns about safe care and treatment. This inspection examined those risks and reported on the findings in the safe and well led domains. This incident is subject to a separate police investigation and as a result this inspection did not examine the circumstances of the incident.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Ashley House Care Home' on our website at 'www.cqc.org.uk'. The last inspection report was carried out 18 and 19 May 2016. At that inspection the service was rated as "good" and was meeting all of the relevant regulations. There was some area for improvement identified regarding the deployment of staff within the service. Our findings at this inspection have not changed the current rating of 'requires improvement' for the key question Safe, the current rating of 'good' for the key question Well-led or the overall rating of 'good' for this service because we did not look at all the areas for the key question Safe and Well-led. We will review all areas of the key questions of Safe and Well-led in full at our next comprehensive inspection.

Ashley House Care Home provides residential and nursing care for up to 47 older people. 25 people were using the service at the time of our inspection. Some of the people living at the home were living with dementia or other long term health conditions.

The home has a registered manager. 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 and associated Regulations about how the service is run.

People felt safe living at Ashley House Care Home. Care and nursing staff had clear guidance to assist people with the risks associated with their care, such as moving and handling and the risks of falls. People's risks had clearly been assessed and clear detailed guidance was available to nursing and care staff.

Management systems were in place to ensure people were kept safe from preventable harm. The registered manager and senior staff ensured action was taken where shortfalls had identified. The service learnt lessons from incidents within the service to prevent future harm.

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

People felt safe living at Ashley House Care Home. Care and nursing staff had clear guidance to protect people from the risks associated with their care. People's risks of falling had clearly been assessed and comprehensive guidance was available to care staff. There were enough nursing and care staff deployed to meet people's needs.

While improvements had been made to the deployment of staff; the rating of 'requires improvement' has not been changed from our last inspection as we did not look at all the areas of the key question of Safe. We will review all areas of the key question of Safe in full at our next comprehensive inspection.

Is the service well-led?

Good

The service was well led.

Management systems were in place to ensure people were kept safe from preventable harm.

The registered manager and senior staff ensured action was taken where shortfalls had identified. The service learnt lessons from incidents within the service to prevent future harm.

Ashley House 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. The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people living at Ashley House Care Home. This inspection examined those risks. This inspection was carried out by two inspectors.

We undertook this unannounced focused inspection of Ashley House Care Home on 1 August 2017. This inspection was prompted in part by the provider's notification to CQC of a significant event. This information shared with CQC indicated potential concerns over safe care and treatment. During this inspection we looked at the two key questions; Is the service safe? and Is the service well-led?

We spoke with three people. Additionally we spoke with nine members of staff which included one nurse, two enhanced care staff, two care staff, the deputy manager (who was also a nurse on duty), the registered manager and two representatives of the provider. We reviewed eight people's care records. We also reviewed management records in relation to staffing and incidents and accidents at Ashley House Care Home.

Requires Improvement

Is the service safe?

Our findings

People's individual risks were assessed by nursing and care staff. People's care plans contained assessments based on people's individual risks in relation to areas such as falls, moving and handling, maintaining safety, nutrition and skin integrity. People's risk assessments were reviewed monthly and where risks associated with people's care had been identified, care plans contained clear guidance for nursing and care staff to follow on how to reduce these risks. For example, one person's moving and handling care and risk assessments plans included details of which hoist and sling care and nursing staff should use to assist people to mobilise safely. Additionally, one person had been assessed by the service as being at a high risk of falling. The person's care assessment detailed how care and nursing staff should manage this, such as the use of a sensor alarm (used in the person's best interest) when the person was in their bedroom which would alert care staff if the person tried to walk unaided. Additional guidance for care and nursing staff included "nurse in communal areas during daytime hours" and "don't leave alone in wheelchair or toilet". When care plans guided care staff to regularly check that people were safe, monitoring records maintained by care staff and checked by nursing and senior care staff showed that these checks had taken place.

Staff knew how to keep people safe. They knew which people were at risk of falling and which people had poor mobility. One said "If someone is at risk of falling, we never leave them alone for long periods. They are checked regularly, and we would try to encourage them to come to the lounge so they can be seen all the time. At night some people have bed rails to keep them safe, sensors or maybe high low beds and crash mats". Another member of staff said "I find that sometimes people will try and get up without help if they're bored or lonely. I find that when they come to the lounge they get involved in the activities and then don't get so agitated or want to get up".

People were involved in managing and assessing their own risks. For example, one person had requested bed rails be in place on their bed as this gave them a sense of security as they were afraid of falling from bed and sustaining an injury. Nursing staff had discussed and assessed the risk of the person staying in bed when the risk assessments on and the person agreed that this was the option they preferred. The person had also agreed to a trial period without the use of bed rails. While the trial period was successful, the person still wished for bed rails to be in place, this person's bed rail risk assessments clearly documented the risk to the person as well as their consent for bed rails to be used. Where other people had bed rails risk assessments in place, these assessments clearly showed that less restrictive options had been considered for each individual person, such as the use of high/low beds (beds where the height is adjustable) and crash mats. When the least restrictive options were not used, there was clear mental capacity documentation in place to show how best interest decisions had been reached.

People were supported to make decisions which may place them at risk. For example, one person had stated that they did not wish to be checked at night, even though they may be at risk of falls if they mobilised independently. This risk had been discussed with the person, and they agreed to use the home's call bell system if they required assistance. Their decision to not be checked at night was respected.

Where people's care needs and risks had changed, nursing staff ensured care and risk assessments had

been amended to reflect these changes. For example, nursing and care staff had identified one person's mobility had deteriorated. Staff had identified the person was no longer able to mobilise independently with mobility aids and now required more assistance. There moving and handling care and risk assessments had been updated to clear reflect the support they required from care staff including using a wheelchair to safely assist the person to move around the home.

Where people were immobile and were unable to change their position without support care and nurse staff protected them from the risk of skin damage through effective assessment of their needs and wellbeing. Where people had been assessed by nursing staff as being at risk of skin breakdown (pressure sores), risk assessments were documented. These assessments detailed how often care and nursing staff should assist people to reposition in order to reduce the pressure on areas of their skin. Repositioning records for each person showed that people had been repositioned in accordance with their assessed needs. Staff knew how often people needed to be assisted to reposition and understood the importance of assisting them. One staff member said, "If someone is in the lounge, we will offer to take them to the toilet, but if they don't want to, we explain that we will just need to take the pressure off for a bit to stop them getting sore".

Where needed, people had pressure relieving equipment to protect them from the risks of skin damage such as air mattresses or pressure relieving cushions. The majority of the air mattresses in place were "self-setting" which meant the mattress would set itself to the correct pressure for the person's weight. When a different mattress was in place which staff needed to set in accordance with the person's weight, the care plan guidance included the correct mattress setting. We checked one of these mattresses, which was not set correctly. Within the care plan it had been documented the setting the mattress should however when we checked it was set at a different setting. We showed this to the Deputy Manager who immediately set the mattress to the correct setting. They also said that they had recently ordered more self-setting mattresses and that the plan was to have just this type in place, to ensure this concern was not repeated.

Care and nursing felt there was always enough staff on duty to meet people's needs. Comments included "Yes, even if someone goes off sick, they (management) get other staff in", and "If anything, we're over our staff numbers, but it's nice because we get to spend one to one time with people" and "Most of the time we're ok for staff." The registered manager explained how staff were deployed around the home and the number of staff they felt needed to be deployed to ensure people were kept safe.

Call bells were accessible to people 24 hours a day. People had call bells within their rooms and care and nursing staff informed us they ensured people had these on them to enable them to call for assistance. The service kept a record of when the call bell system had been used and carried out spot audits on a weekly basis.

People we spoke with felt safe living at Ashley House Care Home. One person told us, "I'm very safe. It's secure here. I'm here for the rest of my life. I am happy and comfortable. The staff are good, they make me feel safe. I can't grumble. Another person when asked if they felt safe responded positively and said "yes."

All staff said they felt people were safe using the service. They said "We keep people safe" and "Yes, I do feel everyone is safe here". Staff also knew how to report any concerns they may have regarding unsafe care. One said "I don't want to be part of any bad care. I would always report it".

People could be ensured that care staff were aware to report any incidents or unexplained bruising of people. For example, care staff had identified an unexplained bruise on one person. The person often accessed the community independently. Care staff informed the nurse who implemented a body map. All staff ensured the bruise had disappeared before discontinuing the body map record.

Good

Is the service well-led?

Our findings

The inspection was prompted in part by notification of a safety incident. The provider took prompt action following the safety incident to ensure people in the home would receive safe care and treatment. The registered manager informed us of some of the actions they and their staff team had taken following this incident. These actions included reviewing the commodes used in the service and removing those which the registered manager had deemed to no longer be suitable for use. Care staff had been involved in reflective learning, where they discussed actions they would take to ensure any potential incidents are reduced. These included ensuring staff were present when assisting people on commodes where a risk had been assessed and managing people's calls for assistance. The registered manager was completing a root case analysis investigation of the incident and would be sharing this information with CQC when completed.

Systems were in place to monitor risks and quality of service and improvements were made when shortfalls were identified. For example, the provider had identified that night staff did not always keep a clear and continuous record of the support they had provided people in the night regarding how often they assisted people to reposition at night. The registered manager and representatives for the provider informed us of the action they were taking to ensure people's records were reflective of the support they received by checking repositioning charts. Records of people's wound care clearly showed their conditions were improving and that they had received the support they required to keep their skin healthy.

The registered manager and senior staff monitored the call bell system for Ashley House to ensure people's call for assistance were answered effectively. Two separate call bell audits were carried out by nursing staff within the home. One reviewed how often the call bell and emergency bell was used within 24 hours and why the emergency bell was used. For example, nursing staff had identified one person was using their emergency bell inappropriately to request a cup of tea. This had been discussed with the person and alternative arrangements, such as calling the receptionist during office hours had been agreed. The other audit reviewed how long it took care and nursing staff to answer people's calls for assistance. Where calls which had taken longer than expected by the provider had been identified there was not always a clear record of why staff took time to answer the bell or any actions that the service was planning to take. For example, one call bell on one day had been activated twice for over an hour before being switched off. We discussed this with the registered manager who reassured us that the bell related to a sensor mat in one person's bedroom. On both occasions the person was down with care and activity staff in the home's lounge or dining room. The service had taken action to identify the reason for these call times. The registered manager and representatives of the provider agreed that they could benefit from recording the action they had taken so that staff would have a record to refer to in future.

Systems were in place to report and investigate safety concerns. The registered manager and deputy manager input all accidents and incidents onto General Manager Quality Metrics (an electronic monitoring system used by the provider) which generated a monthly report. This identified the number of accidents which had occurred to both people and staff every month and actions the service had taken, as well as other areas such as infection control, safeguarding and health & safety. The deputy manager told us it was their responsibility to carry out audits of incidents such as where they occurred and the time they occurred, with

the aim of identifying any trend and taking effective action. They had not completed a monthly audit since September 2016. The deputy manager however showed us records and told us how they reviewed incident and accident forms immediately and took effective action to ensure people were protected from preventable risk. For example, they explained how following a fall from a bed they had rearranged one person's room with their consent to protect them from the risk of falling without using restrictive measures such as bed rails. Incident and accident forms were detailed and clearly documented the actions taken to protect the person as well as lessons which could be shared with all staff. We discussed that incident trend audits were not currently occurring with the registered manager and representatives of the provider and they informed us that immediate action would be taken to complete these again. Records in relation to incidents people had suffered documented the lessons staff had learnt and were implementing to ensure the safety of people living at Ashley House Care Home.

People could be assured the home was safe and secure. Safety checks of the premises and equipment used for assisting people with their mobility were regularly carried out. People's electrical equipment had been checked and was safe to use. People's mobility equipment had been serviced every six month in accordance with manufacturer guidelines. Fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. There were personal emergency evacuation plans for each person. A copy of these plans was kept alongside fire safety documents in the event of an emergency. Fire drills were carried out at different times of the day, a clear record of the date and time of the drill had been recorded as well as the members of staff involved. Actions to improve evacuation had been identified from these drills, such as "slight issue door entry" and the registered manager could explain the learning that had taken place to improve future evacuations.