Ash Lodge Care Home

Ash Lodge Care Home

Inspection report

262 Beverley Road
Hull
Humberside
HU5 1AN

Tel: 01482440359

Date of inspection visit:
02 June 2017

Date of publication:
11 July 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 June 2017 and was unannounced. At the last inspection on 11 June 2015 the registered provider was rated 'Good' and was compliant in all areas we assessed.

Ash Lodge Care Home is situated on a main road into Hull city centre. It is close to local amenities including shops, pubs, library, swimming baths and a park. The home is owned by a partnership and offers support up to 22 adults who have mental health needs. At the time of the inspection, there were 20 people using the service.

The service had 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 2008 and associated Regulations about how the service is run. The registered manager also managed another service within the organisation. This meant they divided their time during the week between the two services.

During this inspection we had concerns about some aspects of the environment caused by domestic shortages and overall governance.

The dining room and some bedrooms required cleaning. External areas leading from both ends of the dining room required sweeping and tidying and more bins were required for the disposal of cigarettes ends. We found domestic and catering hours were insufficient.

There was no structured quality monitoring system. Some checks were carried out, for example on medication, everyday maintenance jobs, and care plans, which had been checked during their input into a new computer system. However, there had not been any environmental checks recorded and no evidence the registered manager and registered provider were aware of the issues we found with cleanliness and specific furniture. The environment was suitable for people's needs, however some items of furniture needed replacement. This related to two settees, some bed bases and mattresses, a wardrobe and a dining table; these were ordered on the day of inspection. There had not been any questionnaires to people in 2016 apart from to four relatives and there was no action plan to record negative comments so it was difficult to see if they had been addressed.

You can see what action we have asked the registered provider to take regarding staffing and governance in the full version of this report.

We found staff knew how to keep people safe from the risk of harm and abuse. The registered provider had policies and procedures to guide staff and they had completed safeguarding training. Staff completed risk assessments for people and there were plans in place to help minimise risk whilst still ensuring people had control of their lives.

The recruitment process had some shortfalls in regards to ensuring people had references in place prior to the start of employment. The registered provider told us they would address this straight away. Other employment checks were carried out appropriately.

Staff supported people to be independent and ensured they gained consent prior to carrying out tasks. People who used the service all had the capacity to make their own decisions. Staff were aware of mental capacity legislation and had completed training in this.

Staff supported people to access community health professionals and monitored their general and mental health, offering advice when required and an escort to appointments.

People's nutritional needs were met. Menus provided people with a nutritious diet with choices and alternatives. Drinks and snacks were served throughout the day and people who used the service could help themselves to hot and cold drinks in the dining room.

People's needs were assessed prior to admission and the registered manager formulated a care plan for each person. These helped to guide staff in supporting people in the way they preferred to be cared for. Some minor amendments were required to ensure all the information was included in care plans; this was mentioned to the registered manager to address. As they were in the process of transferring paper records to computerised ones, they told us this would be completed straight away. One of the directors of the organisation is an approved mental health practitioner and told us they were supporting the registered manager with updating the care plans.

People told us the staff treated them well and had a caring approach. We observed staff had developed good professional relationships with people who used the service. There were activities for people to participate in and staff encouraged people to pursue their own hobbies and interests; staff supported people to access community facilities. An enablement co-ordinator was employed two and a half days a week to support people with activities of daily living and to help prepare them for a move to more independent accommodation.

We saw staff had access to training, supervision and on-going support. This enabled them to feel confident when supporting the people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There was a shortage regarding domestic and catering staff. The impact of domestic shortfalls had led to a fall in cleanliness in specific areas of the service.

The staff recruitment process had shortfalls in relation to ensuring adequate references were in place prior to the start of employment. Other checks were carried out though and references were addressed on the day.

Staff knew how to recognise the signs of abuse and poor practice and what to do if they had concerns.

Medication was well-managed and people received their medicines as prescribed.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A structured quality monitoring system had not been developed yet so issues found during the inspection had not be identified by staff.

Although people who used the service had meetings and the culture of the organisation was one of listening to them, there had not been any questionnaires completed last year or so far in 2017. The questionnaires would help to obtain people's views about the way the service was managed.

Staff and people who used the service told us the registered manager and registered provider were available and they felt able to raise concerns with them if required.	

Ash Lodge 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 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 2 June 2017 and was unannounced. The inspection team consisted of one adult social care inspector.

The registered provider had completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked our systems for any notifications that had been sent in as these would tell us how the registered provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day. We spoke with four people who used the service and six other people completed a short questionnaire during the inspection. We spoke with the registered manager, the enablement co-ordinator, a support worker and a domestic worker. The enablement co-ordinator was employed to support people to maintain and develop their activities of daily living skills to help when moving to more independent accommodation. We also spoke with the registered provider and a director of the service.

We looked at four care files for people who used the service. We looked at the medication administration records (MARs) for all 20 people. We looked at 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 in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These

included recruitment files for three staff, training records, the staff rota, menus, maintenance of equipment records, quality assurance audits, complaints management, and minutes of meetings with staff and people who used the service, We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service and staff were available to provide them with appropriate support when they needed it. They also said they received their medicines on time. Comments included, "Yes, I do feel safe", "It's alright here", "I love it here" and "I am lucky to live here. Staff sort out any issues that arise in the home." Other comments included, "There is always enough staff; there is always adequate cover" and "I'm on lots of medication but it's well-managed by staff."

We found some shortfalls with the recruitment process which meant that full employment checks were not always in place prior to staff starting work at the service. Some checks were made prior to new staff starting employment at the service, which included an application form, an interview and a disclosure and barring check to assess their suitability to work in care settings. However, in one staff file we saw references were not in place prior to them starting work. In another staff file there was only one reference, which was handwritten and not dated; this had not been followed up and verified. The same person had an application form which did not give a full picture of their work history and there was no record that the gaps had been explored with them. In the third staff file, the candidate had two references but neither of these was dated so it was difficult to audit if they had been seen by the registered manager prior to them starting work. The registered provider told us they would address these issues straight away. Following the inspection, the registered manager told us this had been addressed.

People told us staff were available to support them. People who used the service were all independent with personal care needs and only required prompts and supervision at times. There were two support workers on duty each day and night, seven days a week. An enablement co-ordinator worked at the service two and a half days a week to support people to develop their skills with a view to them moving to more independent living. The registered manager worked at the service two and a half days a week, opposite shifts to the enablement co-ordinator, so there was always at least three staff on duty Monday to Friday. There was a domestic worker on duty five mornings a week and support workers prepared meals.

Insufficient domestic staff had impacted on the cleanliness of the environment and some people who used the service required more key worker support to ensure their bedrooms were sufficiently clean, tidy and safe. The service is a large building (two three-storey houses knocked into one), and as well as insufficient domestic hours, there was also confusion around domestic roles and responsibilities. For example, whose job it was to replenish paper hand towels and soap in toilets, and checking that the toilets were clean for the next person to use. This meant some toilets and bathrooms did not have soap and hand towels; these were addressed on the day and the registered provider told us they would ensure people were aware of their responsibilities in this area. External areas leading from both ends of the dining room required sweeping and tidying; there were numerous cigarette ends, discarded tea bags and beer cans in the rear courtyard. More bins were required for the disposal of cigarette ends. We saw staff supported people who used the service to sweep up these areas later in the day. The dining room floor required cleaning and food debris cleared from tables, once they had been used; the patio door frames at each end also required cleaning. Some bedrooms required cleaning, cupboards and drawers sorting out, and we found a plate filled with dried food on the floor in one person's room.

Staff had access to personal and protective equipment such as gloves, aprons and hand sanitiser when required. We saw there was a plentiful supply of cleaning products and equipment. We discussed cleanliness and tidying of bedrooms and external areas with the registered provider who initiated additional domestic staff on the day of the inspection to start to address the issues. They agreed to extend domestic hours on a permanent basis and to look at catering hours to assist care staff in having more one to one time with people.

Not having sufficient staff on duty was a breach of regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

You can see what action we have asked the registered provider to take regarding staffing at the back of this report.

The registered provider had policies and procedures in place to guide staff in dealing with allegations of abuse or poor practice. Staff knew how to keep people safe from the risk of harm and abuse. They had completed safeguarding training and in discussions were clear about what constituted abuse and what to do if they had concerns or witnessed poor practice. People had risk assessments completed; these included areas such as behaviour, alcohol misuse, deteriorating mental health and self-harm. The risk assessments were clear and gave information to staff about how to support people without restricting their choices and decision-making.

We found medicines were well-managed. Medicines were obtained, stored and administered to people safely in line with their prescriptions. There was a designated store room for medicines, which was monitored to ensure the temperature remained stable and in line with manufacturer's instructions for safe storage. There was a designated fridge and a specific cupboard for those medicines requiring more secure storage. There were some minor recording issues which were mentioned to the registered manager to address. Staff who administered medicines had received training.

Equipment used in the service was checked, maintained and serviced when required.

Good

Is the service effective?

Our findings

People told us staff provided them with care and support that met their needs. They also said they were able to have control over their lives and make their own choices and decisions. Comments included, "I give it [choice and control] nine out of ten", "Yes, I control my life" and "Yes, I do have control and can make choices", "I give them ten out of ten for training" and "I think the staff are better trained than I am."

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. People who used the service all had capacity to make their own decisions. Staff were clear about how they promoted people's choices and decision-making and with how they gained consent prior to carrying out any tasks. Comments included, "People have all sorts of choices such as meals, routines and what they do during the day; everyone can wash and dress themselves."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff were aware of MCA and DoLS and had completed training. There were no people subject to DoLS at the time of the inspection.

We saw people had access to health and social care professionals when required. These included GPs, consultant psychiatrists, community psychiatric nurses, social workers, dieticians and a mental health crisis team in emergencies. People also attended dentists and opticians when required. Staff supported people to attend appointments when these were arranged. We saw a letter from the previous week regarding dietetic and monitoring advice. This had not been actioned yet but the person who used the service had put on weight since the referral was made. The registered manager told us they would ensure the correct amount of monitoring charts would be completed for when the dietician needed them.

People who used the service liked the meals provided to them. Comments included, "The meals are fantastic here; I'm well-fed." One person would like to see more fish and chips and burger and chips on the menu; this was passed on to the registered manager. The menus indicated a range of breakfast options such as cereals, toast and preserves, and hot food such as boiled or scrambled eggs and tomatoes on toast. The main meal was served in the evening apart from weekends and offered two choices. On Saturday, lunch consisted of a 'breakfast fry-up' and a roast dinner was served on Sundays; lunch was a lighter meal throughout the week. There was food available for supper, and snacks such as biscuits and cakes were served with hot and cold drinks throughout the day. There was also a table set out in the dining room with flasks so people could help themselves to coffee and tea. People had a care plan to guide staff on how to meet nutritional needs and their weight was monitored.

Records showed staff had access to training, supervision, appraisal and support. All staff had completed the Care Certificate which formed the foundation of training in 15 areas. Refresher training was completed. In

discussions, staff told us they had completed relevant training and felt confident when supporting people. One support worker was completing a level five in management. One member of staff did comment that they would prefer more face to face training and less reliance on e-learning for some subjects. This was mentioned to the registered manager to discuss with the registered provider. The training plan was a mixture of e-learning, booklets and face to face practical training, for example first aid.

Good

Is the service caring?

Our findings

People who used the service told us they liked the staff team and were able to have a laugh and a joke with them. They also said staff acknowledged their privacy and treated them with respect. Comments included, "Yes, they are caring and yes, they do [respect privacy and dignity]", "I'm happy with my room; I have no issues", "Staff are always there for advice and support", "I've made quite a lot of friends here" and "I think the staff are alright."

We observed staff were patient, attentive to people and had a caring approach. For example, we observed staff stopped and chatted to people at specific times and offered drinks and biscuits throughout the day. Staff had developed good relationships with people who used the service. They knew them very well, were friendly and had a light hearted banter with some.

We observed staff knock on bedroom doors before entering and in discussion, they were clear about how they ensured people had their privacy, dignity, decision-making and independence maintained. They spoke about an ethos of encouraging people to do what they could for themselves, supporting them with activities of daily living and making sure they respected people's need for privacy and their own space.

Staff asked people what they wanted for lunch and the evening meal each day, reminding them of the choices available. We saw people had choices about the times of rising and retiring. Some people chose to stay in their bedrooms and only came down at lunchtime when they were ready. Some people accessed community facilities independently and some were supported by staff.

We saw staff supported people to maintain links with and visit their family and friends. The enablement co-ordinator told us how they supported a person once a month to visit their family and stayed with them to reduce their anxieties. The initial visits had been built on and now were very successful; the person was able to spend quality time with their relatives.

People were provided with information in the service. For example, there were notice boards advertising planned trips and the last ratings of the service by the Care Quality Commission and Environmental Health Officer. There was a service user guide which gave a description of the service provided to people and a statement of purpose which went into more details. Both of these were available to people. The service user guide made it clear that although the service supported people aged 18-65 years old with a mental health need, they would not ask people to leave when they reached the upper age limit. People would be reassessed at this point to ensure the service was able to continue to meet their needs. The service user guide described Ash Lodge as 'people's home' and stated this was made clear to staff during their interview and selection process.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the registered manager's office. People's reviews were held in their bedroom or a quiet area. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were

password protected. Staff records were also held securely in the manager's office.

Good

Is the service responsive?

Our findings

We saw staff were responsive to people's needs and took action when these changed. People said they completed various activities within the service and outings with other people but at times occupied themselves. Comments included, "I get my own money and shop for myself", "She [registered manager] lets us do what we want", "I'm going to Flaming Land [theme park] and the cinema", "I do various things", "I went to the theatre last year and a barbeque last week" and "Yes, there are loads of activities."

People had assessments of their needs completed and staff obtained those assessments completed by health and social care professionals. The information was used to develop plans of care to guide staff in how to support people in the way they preferred. Staff were in the process of inputting assessment and care plan information into a new electronic system, so currently had both paper and computerised records for people. Staff spoken with were familiar with the computer system and had received training in order to input and extract the information they required.

We saw people's care plans included information about their likes, dislikes and preferences. Staff said they had time to read the plans as they recorded events about people who used the service several times a day. The care plans for some people contained detailed information about the effects of their behaviour but we found the description of staff support could be developed further. In discussions with staff, they knew people's needs well and how to support them in a person-centred way during escalations of risk-taking behaviour. The registered manager told us they would address specific care plans to ensure the actions staff take are clearly documented in them.

Staff described how they were delivering individualised care to people. For example, they supported one person with their medicine management. The person came to staff for their medicines and they were supervised dispensing and taking them to ensure this was done correctly.

There were activities for people to do within the service such as games, knitting, reading magazines, watching television, listening to music and chatting to staff and each other. The enablement co-ordinator told us about the activities of daily living they supported people with. This included doing their laundry and shopping. They had ensured people had their voting cards for the General Election and would be offering support to them so they could attend a polling station if they chose to exercise their citizenship rights. People accessed the local community for shops, cafes, pubs, the cinema, bowling and other entertainment venues. There were trips organised to the coast, a buffet restaurant and a theme park; the registered provider paid for transport and meals out. People told us about an organised barbecue they had attended at one of the registered provider's other services. A lot of people occupied themselves and had their own interests, for example one person played the guitar and another person liked to go and browse in charity shops. There was a covered shelter at the rear of the property for people who wished to smoke.

The registered provider had a complaints policy and procedure. This described timescales for acknowledging complaints, investigating them and responding to the complainant. The procedure provided details of how to escalate complaints to other agencies. These included the local authority complaints

manager in East Riding, where the registered provider's other services were, but did not provide information about their counterpart in Hull. This was mentioned to the registered manager to address. People told us staff listened to them and would address any concerns they had. Comments included, "I would speak to staff if I had any concerns" and "I have one of the biggest mouths; they know when I'm upset."

Requires Improvement

Is the service well-led?

Our findings

People who used the service knew the registered manager's name and said they could approach them if they had concerns. Comments included, "We have a good manager", "I think she should be stricter", "Yes, I think she [registered manager] is good" and "I think she is bossy [laughing], kind and helpful; I give her ten out of ten." Other comments about the ability to express their views included, "We have resident's meetings" and "We have resident's meetings now and again where we are asked our feelings."

We found shortfalls in the quality monitoring system. There was no structured approach to quality monitoring which meant that although checks may have been carried out, there was no record of this and no action plan to address any issues. For example, we found some cleanliness issues and furniture that needed replacing but this had not been identified. There was no thorough environmental audit completed although staff identified any minor jobs that needed completing in the book used by maintenance personnel. They ticked off the jobs when completed. Staff checked medicines on a monthly basis and the inputting of care plans into the new computer system meant these had been looked at but not audited in depth yet.

The registered manager showed us a monitoring tool that would look at all aspects of the service but this had not been used yet. The tool may help to focus attention on areas to check for any improvements. The registered manager was new in post and eager to ensure there was an effective quality monitoring system developed and embedded into practice. They stated this would include checks carried out, people's views being sought and measures put in place to rectify shortfalls.

There were meetings for staff and for people who used the service. This enabled people to be able to express their views. There had been a survey for relatives in October 2016 and four responses were held in the file but there was no collation of their views and no action plan to address any negative comments. The registered manager was unable to locate questionnaires for people who used the service, staff, and health and social care professionals in 2016. We located two completed questionnaires for people who used the service but they had no date on and the registered manager was unsure when these had been completed.

Not having an effective quality monitoring system that identified shortfalls so that issues could be addressed in a timely way was a breach of 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

The registered provider and one of the directors were involved in the service and visited to offer support and advice to the registered manager. They had not completed any environmental checks in depth when they visited but stated this would be discussed each time they attended the service in future. The registered provider showed us an interim plan of actions they had formulated during the inspection as a result of initial findings. This included the replacement of specific furniture items, which were ordered during the inspection and ensuring additional domestic hours.

Staff told us the registered provider and registered manager were approachable and if they were at the other

service, they could contact them by phone. We spoke with the registered manager about the culture and values of the organisation and it was clear this was focussed on enabling people who used the service to lead as independent a life as possible. The registered provider's statement of purpose refers to important core values, listening to and involving people in decisions and recognising staff as an important resource.

The registered manager was aware of their registration responsibilities with regards to notifying agencies of incidents which affected the safety, health and welfare of people who used 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured there was a systematic approach to quality monitoring to enable shortfalls to be identified and improvements made in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were always sufficient domestic and catering staff on duty to meet the needs of service users who live there.