Care Quality Commission

Leacroft Lodge Limited

Ashcroft Hollow Care Home

Inspection report

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Ratings

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

Overall summary

We inspected this service on 16 and 22 July 2015. The inspection was unannounced. At our previous inspection in June 2013, the service was meeting the regulations that we checked.

The service provided accommodation for up to 45 people. Thirty five people were living at the home on the day of our inspection.

There was a registered manager in post at the time of our inspection. 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 observed that at times people waited for support. Staffing levels were not reviewed to ensure they were sufficient to meet people's individual needs at all times.

The staff did not fully understand and act in accordance with the requirements of the Mental Capacity Act 2005. People's rights were not respected when decisions were made on their behalf. At the time of our inspection, no

Summary of findings

one had a Deprivation of Liberty Safeguarding (DoLS) authorisation in place but the manager had submitted referrals to the local DoLS team and decisions were awaited.

The provider carried out some checks to assess the quality of the service but these were not always effective. Information from accidents and incidents was not used to minimise the risk of further repeated accidents or incidents. There were no audits in place to identify shortfalls we found with the quality of care plans or medication charts. The provider did not have adequate systems in place to gather people's opinions to enable them to make improvements to the service where necessary.

Staff were supported and trained to meet people's individual care needs. Most of the staff told us they felt supported by the manager but some felt their concerns were not always listened to.

People living at the home told us they felt safe and their relatives felt they were well looked after.

People's risk of harm was being assessed and there was guidance in place to manage people's risks. Staff understood their responsibilities to keep people safe from harm.

People told us they liked the staff and told us they looked after them well. People were able to make choices about how they spent their day and staff respected their individual wishes. People felt able to talk to staff about any concerns they had and felt confident they would be listened to. People's complaints were recorded and investigated.

People were supported to take part in a range of activities and social events at the home. Relatives were able to visit freely and were kept informed about their relation's care and support needs.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Staffing levels were not reviewed to make sure they were sufficient to meet people's individual needs at all times. Staff were recruited safely and understood their responsibilities to keep people safe. Appropriate arrangements were in place to minimise risks to people's safety in relation to the premises and equipment.

Requires improvement

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

Staff did not fully understand and act in accordance with the requirements of the Mental Capacity Act 2005. Staff received the training and support they needed to provide people's care effectively. People were supported to maintain good health and access other healthcare professionals when they needed them.

Requires improvement

Is the service caring?
The service was caring.

Staff knew people well and had positive, caring relationships with people. People were able to make choices about their day to day routine. Relatives were made welcome and kept informed about their relation's care and support.

Good

Is the service responsive?
The service was responsive.

People told us they received care and support in accordance with their wishes. Care plans were reviewed and updated to reflect people's changing needs. People were supported to take part in activities that met their individual needs. People's complaints were investigated and responded to.

Good

Is the service well-led?
The service was not consistently well led.

The provider did not have suitable arrangements in place to monitor and improve the quality and safety of the service. The manager was not visible to people and the staff were not always well led.

Requires improvement

Ashcroft Hollow 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.

The inspection was undertaken on 16 and 22 July 2015 by two inspectors and was unannounced. Before the inspection we reviewed the information we held about the service. We reviewed information of concern we had received about the service. We also looked at feedback we had received from relatives of people that lived at the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send us by law.

On this occasion, we had not asked the provider to send us 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.However, we offered the provider the opportunity to share information they felt relevant with us.

We spoke with six people who lived at the home and six relatives. We spoke with five members of care staff, one nurse, three housekeeping staff and a member of the administrative staff. We also spoke with one health care professional. We observed care and support being delivered in communal areas and observed how people were supported to eat and drink at lunch time.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. We used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care records to see how their care and support was planned and delivered. We reviewed four staff files to check people were recruited safely. We looked at the training records to see if staff had the skills to meet people's individual care needs. We reviewed checks the manager and provider undertook to monitor the quality and safety of the service.

Requires improvement

Is the service safe?

Our findings

We spent time observing care in the communal areas of the home. We saw that call bells were not answered promptly and at times there were no staff to support people in the communal lounge. Throughout our inspection, we saw that staff were busy and at times, we saw people had to wait for support. For example, we heard one member of staff ask a person to wait while they finished what they were doing because nearby staff in the dining room were busy helping other people. At lunchtime, all the staff on duty were either helping people to eat their meals in the dining room or supporting people in their rooms.

We received information that people sometimes waited for support from staff that raised concerns that there weren't enough staff to meet people's needs at all times. Relatives we spoke with told us staff were always very busy. One relative told us, "Staff work extremely hard and have too much to do". Most of the staff we spoke with told us they were short staffed. One member of staff told us, "At times we need more staff because people are frail and we can be stretched when their needs fluctuate". Some staff told us they were leaving because they could not always give people the support they needed. One said, "We can't give the care we want, we don't have the time". The manager told us staffing levels at the home were based on occupancy levels and did not take into account people's dependency levels. They told us staffing numbers had been maintained at the levels set by the previous manager. This meant staffing levels were not reviewed to make sure they were sufficient to meet people's individual needs at all times.

This was a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw and people told us they got their medicines on time. One person told us, "I always have my tablets no problem". Medicines were administered at the home by the nurses and a senior member of the care staff. We saw that medicines were stored securely in the home in line with legal requirements. We observed staff ask people if they needed pain relief medicines and saw there was a protocol in place for administering medicines on an 'as required' (PRN) basis to protect people from receiving too little, or too much medicine. Where people could not communicate their need for the medicine, we saw pain management assessments were in place to ensure staff could identify the person's need for pain relief. This showed that people received their medicines safely.

People we spoke with told us they felt safe living at the home. One person told us, "I'm safe here and my wife thinks I'm safe". One relative told us, "I've no worries about [Name's] safety, I know all the carers and I can tell [name] is well looked after". Another relative said, "I think [name] is safe, I'd move them otherwise". Staff told us they had received safeguarding training and were able to tell us about the different types of abuse and the actions they would take if they had any concerns about people. One member of staff said, "I would report it, full stop, it shouldn't happen". Staff told us they were confident any concerns were taken seriously and appropriate action would be taken. The manager told us and records showed that they co-operated and worked with external staff involved in safeguarding investigations. For example, the manager had attended recent safeguarding meetings in relation to a person who was subject to a safeguarding enquiry prior to coming to live at the home. This showed the manager and staff understood their responsibilities to keep people safe from abuse.

In the care plans we looked at we saw the manager assessed risks to people's health and wellbeing. Where risks were identified, the care plans described how staff should minimise the identified risk. Staff we spoke with knew about people's individual risks and explained the actions they took and the equipment they used to support people safely. For example, staff told us about person who had a pressure cushion to minimise the risk of damage to their skin. We saw this was being used. This showed staff had the information they needed to help to keep people safe.

Risk assessments and a planned programme of checks were in place, to minimise the risks to people's safety in relation to the premises and equipment. These included servicing and maintenance arrangements for fire alarm systems, hot water systems, call bells and equipment including bed rails and the hoists.

Staff told us their references were followed up and records confirmed that a Disclosure and Barring Service (DBS) check was carried out before staff started work. The DBS is a national agency that keeps records of criminal

Requires improvement

Is the service safe?

convictions. The manager checked nurse's registrations annually. This meant the provider assured themselves that staff were suitable to work with people who used the service.

Requires improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). Where people cannot make decisions for themselves, the MCA sets out the actions that must be taken to protect people's rights. Care plans we looked at did not show how people were supported to make decisions. Where people were unable to consent, mental capacity assessments and best interest decisions had not been completed for consent regarding the use of equipment or end of life wishes. This did not demonstrate that the relevant people had been involved to ensure decisions had been made in the person's best interest. Staff we spoke with had not undertaken training on the Mental Capacity Act and did not have an understanding of the processes to follow to ensure that when people lacked capacity to make decisions, they were made in their best interests and in line with legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, no one had a DoLS authorisation that had been approved but the manager had identified that some people may be subject to a level of supervision and control that may amount to a deprivation of their liberty. They told us they had contacted the local DoLS team for advice and four referrals had been made for approvals. This showed us that the manager had taken action to ensure people were not deprived of their liberty unlawfully.

Staff told us they were provided with support and training to care for people effectively. Comments from people and their relatives demonstrated that staff had the knowledge and training they needed to provide people's care. One relative told us, "[Name's] moods have become more pronounced, staff understand their needs and look after them very well". Staff told us the manager checked their competency and understanding of training. Staff were also supported to check their practice by senior staff, who acted as mentors, for example in moving and handling. One senior member of staff told us, "My eyes are everywhere checking to make sure staff move people safely". Staff told us they received supervision three or four times a year which gave them an opportunity to review their training needs and receive feedback on their performance.

We saw that new staff received induction training and had the opportunity to shadow experienced staff to give them time to get to know people's needs before they worked independently. An agency member of staff told us they had received an induction on their first day at the home and told us they were supported by a senior member of staff.

People told us the meals were good and included foods they liked. One person told us, "Can't grumble about the food, it satisfies me and there's always something I like". At lunchtime we saw people were offered a choice of meals and drinks and alternatives were offered when people asked for them. We saw people being offered snacks and drinks throughout the day which showed people were supported to have enough to eat and drink to maintain good health.

Care plans we looked at included an assessment of the person's nutritional risks. We saw that people who were assessed to be at risk of poor nutrition had their food and fluid intake monitored.. Staff told us they raised any concerns with the nurse on duty and we saw action was taken to refer them to their GP or the dietician.

The kitchen staff had information that detailed people's dietary requirements, which ensured people were offered a diet that met their health needs and preferences. The cook knew about people's individual needs and explained how the menu was adapted to minimise risks to people's nutrition. For example, people with swallowing problems were provided with a pureed diet. The cook also told us they had received advice on making pureed food look more appetising.

A visiting health professional told us they had a good working relationship with all the staff. They told us, "Staff keep me well informed and up to date, in person or by telephone. Staff are proactive in asking me to visit". People told us that they were supported to maintain good health and were able to see their GP and other health professionals when they needed to. Care plans included records of visits and advice from other health professionals such as speech and language therapists, podiatrist and the optician.

Good

Is the service caring?

Our findings

People and relatives we spoke with were happy with the staff. One person told us, “The girls are good”. Another said, “The staff are nice, they look after me well”. We saw staff chatting and joking with people and saw there was a relaxed and friendly atmosphere. A relative told us, “The staff are always smiling; it makes me glad [Name] is here”. Another said, “Staff have been brilliant, [name] has really been well looked after”. We saw that staff treated people with kindness and were attentive to them. A member of staff spent time talking to a person who was upset because the person they normally sat with had chosen to stay in their room. They calmed the person down by talking about what else they could do that day. Staff told us they worked hard to make people feel at home. One member of staff told us, “This is their home, we make them comfortable, be on their level, have a laugh and a joke, I love the way they are. Another said, “We are a family, I instil that in the residents”. This showed staff developed positive, caring relationships with people and their relatives.

People told us they were able to make choices about their day to day routine. They told us they could choose what time they got up and went to bed, and some people told us they preferred to stay in their rooms. One person said, “”I like being in my room but someone always comes in to chat to me and see if I want anything”. Another person told us, “Staff ask me what time I want to get up. I usually get up at about 7:30 but I can stay in bed longer if I want”. Some of the care plans we looked at showed that people had made decisions about their care. For example, one person preferred not to use a piece of equipment that had been recommended for them and we saw this was being respected.

Relatives we spoke with told us the staff were very welcoming and they could visit any time. One told us, “You can breeze in when you want”. Another said, “Everyone makes us feel welcome”. They told us the staff kept them informed about their relative’s care and support and involved them in decisions appropriately. One relative told us, “Communication is good, I’m always involved in decisions. [Name] tells me what’s happened and the staff will reiterate this to me”. Another said, “Staff ring me if anything has happened and keep me updated”.

Staff gave us examples of how they promoted people’s privacy and dignity. One member of staff told us, “When someone is unwell, if residents ask what is wrong I make sure things are kept confidential unless they tell me it’s ok to make them aware”. Relatives told us their relatives were always well presented when they came to visit. One relative told us, “Staff change [Name’s] clothes if they spill anything”. We saw that staff were discreet when moving people using equipment and they covered the person’s legs to maintain their dignity.

Good

Is the service responsive?

Our findings

People told us staff knew about their needs and preferences and provided care and support in the way they wanted it. One person told us, "Everyone knows how to help and support me. I prefer to stay in my room and staff come to me if I need anything". We also received examples of how staff respected people's wishes from relatives. Staff told us how they supported people who were not able to communicate their wishes verbally. One member of staff told us they recognised the person's mannerisms and had developed some hand gestures that the person responded to. We observed the member of staff use these gestures and saw that the person responded positively.

People and their relatives told us they enjoyed the activities at the home and were supportive of the activities co-ordinator. One relative told us, "The activities co-ordinator is superb, they get everyone going". Each person had a personalised activities plan, developed with the support of an occupational therapist, to ensure it met their individual needs. We observed the activities co-ordinator supporting people individually in their rooms and working with a group in the dining room. They told us, "I take the activities with me to their rooms. It helps them to stay in touch with what is going on in the home. A relative told us, "The activities co-ordinator tries to get [name] involved with activities even though they are in their room, which is great". Relatives told us staff kept a photographic record of people pursuing their interests and the events that took place at the home. They told us staff showed these to them when they visited and this kept them informed about what their relative had been doing. Photographs were also on display in the entrance hall showing different activities to remind people of occasions they had enjoyed.

People were encouraged to take part in activities such as indoor gardening, which helped to maintain their dexterity. People were supported to plant up vegetables such as potatoes and when they were ready, the pots were brought in for people to dig them up and have them for lunch. We saw pots were placed around the home so that people could see progress from indoors. We saw people sat in the dining room enjoying a performance from a singer. The activities co-ordinator was happy to see that a person who hadn't spoken since coming to the home tried to speak into the microphone. This showed staff cared about people's quality of life.

Care plans we looked at had been reviewed as required. Relatives told us they were kept informed about their relative's wellbeing and they were included in reviews. One relative told us, "I get invited to reviews and decisions aren't made without consultation". Another said, "Staff always consult me when things are changing".

People told us they felt able to raise their concerns with staff and felt they would be listened to. One person told us, "If I'm not happy I tell them and they listen to me". A relative told us, "You can always go to staff and say this is what's happening and they always listen". We saw that records of formal complaints were kept and these were fully investigated and responded to. The provider had a complaints procedure in place which was promoted to people living at the home through the home's Welcome Pack.

Requires improvement

Is the service well-led?

Our findings

There was a system for recording accidents and incidents at the home and these were monitored by the provider. However, there was no evidence that the manager used the learning to minimise the risk of further repeated accidents or incidents by discussing them with staff at meetings.

There were no audits in place to check the quality of care plan entries or medication chart entries to monitor if these were accurate and appropriately written. We found that some of the documentation was not written in the most appropriate manner, for example where staff recorded people's need for support with eating and drinking. We found that gaps in the medicine administration records (MAR) were not always followed up and changes to people's medicines were not always countersigned in accordance with good practice. Staff told us they had been trained to administer medicines and had their competence checked periodically by the manager. However, the manager could not provide us with evidence of any formal training received by staff and competence checks had not been documented to identify where any improvements were needed.

Staff told us they had meetings with the manager which gave them opportunity to raise concerns but some staff felt the manager did not always listen to them. For example, two staff told us the manager had not responded to their concerns which they felt may have an impact on how quickly they responded when people asked for support. We discussed this with the manager who told us they were recruiting new staff and we saw they discussed sickness concerns with individual staff to address these issues.

We asked people and their relatives if they knew who the manager was. Most of the people we spoke with knew the manager as matron but did not know they managed the service. One relative told us, "I'm not sure who is totally in charge, I usually speak to a member of staff if I have any concerns."

The provider sought people's opinion of the service through an annual questionnaire and the results were monitored and improvements had been made in some areas. For example, new bed linen and towels had been purchased.

The manager understood the responsibilities of registration with the Care Quality Commission and notified us of important events that occurred in the service promptly which meant we could check that appropriate action had been taken.

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.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider based staffing numbers on occupancy levels and did not take into account people's individual needs to ensure there were sufficient staff to keep people safe at all times.** **Regulation 18 (1).**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Where a person lacks mental capacity to make an informed decision, or give consent, the provider did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.** **Regulation 11 (1)**