Ashton Manor Care Home Ltd

Ashton Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 September 2018 and was unannounced. Our last inspection was in July 2017 where we identified one breach of the legal requirements in relation to medicines and infection control. At this inspection, the provider had taken action to meet the legal requirements of the regulations.

Ashton Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ashton Manor Nursing Home provides care to up to 39 people in one adapted building. They provide support to older people, people with physical disabilities and long term medical conditions. They also provided support to people living with dementia. At the time of our visit, there were 32 people living at the home.

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.

Risks to people were assessed and actions were identified and implemented to keep people safe. Staff understood people's clinical needs and appropriate support was provided to meet them. People had regular access to healthcare professionals and staff worked collaboratively with them. People's medicines were managed and administered in line with best practice and staff had received medicines training and their competency had been assessed. Nursing staff had support to maintain their competencies and the provider had checked that nurses were registered with the Nursing & Midwifery Council (NMC).

There were sufficient numbers of staff to meet people's needs safely and the provider had carried out checks on staff to ensure they were suitable for their roles. Staff underwent training before working with people and this had been regularly refreshed. Staff had regular one to one supervision meetings and there was an appraisal and competency framework in place to allow staff to develop themselves. Staff felt supported by management and there were systems in place to enable communication between staff.

Staff understood their roles in safeguarding people from abuse and records showed staff responded appropriately to incidents. The provider monitored incidents and clinical risks such as weight loss and infections. There were a variety of checks and audits undertaken at the service to identify and respond to any issues. People were regularly asked for their feedback and regular meetings took place to involve people in the running of the home. There was a complaints policy in place and records showed complaints were responded to in line with this policy.

People's care was planned in a person centred way and staff knew what was important to people. We

observed that staff were kind and caring and got on well with people. Staff offered people choices and involved them in their care. People were encouraged to maintain skills and independence and staff provided support in a way that was respectful of people's privacy and dignity. End of life care was planned sensitively and delivered in a personalised way, by trained staff.

Staff supported people to eat food that matched their preferences and met their dietary needs. There was a wide variety of activities taking place at the home which covered a range of interests. People lived in a clean home environment that had been adapted for their needs. Relatives told us they were made to feel welcome and staff knew what was important to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People lived in a clean home environment with measures in place to reduce the risk of the spread of infection.

Staff administered people's medicines safely and they were stored and managed in line with best practice.

There were sufficient numbers of staff to keep people safe and appropriate checks were undertaken to ensure staff were suitable for their roles.

Risks to people were assessed and plans were implemented to keep people safe. Staff responded appropriately to accidents or incidents.

Staff understood their roles in safeguarding people from abuse.

Is the service effective?

Good

The service was effective.

People's clinical needs were met and staff supported people to access healthcare professionals.

Staff had appropriate training and support for their roles. Nursing staff benefitted from clinical support and supervision.

People were prepared food in line with their preferences and dietary needs.

Staff gathered important information about people's needs before they came to live at the home.

The home environment was adapted for people's needs.

People had consented to their care and where they were not able to, the Mental Capacity Act 2005 had been followed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff that knew them well.

Staff involved people in their care and enabled them to make choices.

People were encouraged to maintain independence.

Staff provided care in a way that was respectful of people's privacy and promoted their dignity.

Is the service responsive?

Good

The service was responsive.

People's care was planned in a person-centred way.

Staff regularly reviewed people's needs and responded to any changes.

End of life care was planned in a sensitive and personalised way.

People were informed of how to raise a complaint and complaints had been handled in line with policy.

Is the service well-led?

Good

The service was well-led.

Management carried out a variety of audits and checks to monitor and improve the quality of care people received.

Staff felt supported by management and were encouraged to make suggestions and communicate effectively.

People were involved in the running of the home and their feedback was regularly sought.

The provider had good links with stakeholders and the local community.

Where required, the provider had notified CQC of events that they were required to by law.

Ashton Manor Nursing 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 04 September 2018 and was unannounced.

The inspection was carried out by one inspector, a specialist advisor nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority and the local clinical commissioning group (CCG).

Before the inspection the provider sent us a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

As part of the inspection we spoke with seven people and three relatives. We spoke with the registered manager, the clinical lead, one nurse, three care staff and a care companion. We reviewed care plans for six people, including risk assessments and daily notes. We looked at medicines records, mental capacity assessments and applications to deprive people of their liberty. We also looked at a variety of audits, surveys, meetings minutes and other documents relevant to the management of the service.

Good

Is the service safe?

Our findings

At our inspection in July 2017, we found lifting equipment was shared between people, presenting an infection control risk. We also found hazardous substances were not always stored securely and staff did not follow best practice when administering medicines. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection, the provider had made improvements to meet the requirements of the regulation.

People told us that they received safe care and treatment. One person said, "If anything goes wrong, you can call someone." Another person said, "It's a secure surroundings." A relative told us, "[Person] is certainly safe here. I've not had any worries at all about that."

Actions were taken to reduce the risk of the spread of infection. The home environment was clean and we observed domestic staff cleaning throughout the day. Domestic staff followed a cleaning schedule and we saw evidence of regular checks by management of cleaning work that was carried out. Communal areas and people's rooms were free from clutter and smelt clean and fresh. In response to our findings at the last inspection, the provider had introduced additional moving and handling equipment to ensure that items were not shared between people. We saw that people had their own equipment in their rooms and staff were observed supporting people to move using these. Staff were also observed washing their hands and using personal protective equipment (PPE) when required.

People's medicines were managed and administered safely. Medicines were administered by trained nurses who had their competency assessed. We observed medicines being administered and saw that best practice was followed. Medicine administration records (MARs) were completed after staff administered medicines to people. The MARs seen were accurate, with no gaps. Where people had not been administered their medicines, staff had accurately recorded the reason why.

Information about people's medicines was kept up to date. Where people received medicines on an 'as required' (PRN) basis, protocols were kept in records which documented when staff should offer and administer the medicines. For example, one person was prescribed PRN pain relief medicine. There was a protocol clearly documenting what the medicines was for, the signs of pain and how often it could be administered. We saw staff asking this person about pain, in line with the protocol. Medicines were stored in secure areas and regular checks were done on the numbers of medicines kept. The provider carried out frequent medicines audits to check medicines were being managed and administered safely.

There were sufficient numbers of staff present to meet people's needs. The provider calculated staffing levels based on people's needs and rotas showed these numbers had been sustained. We received feedback from one person that staff were rushed and they sometimes had to wait at busier times. We also heard call bells ringing, however in each case they were answered within four minutes, in line with the provider's policy. We provided this feedback to the registered manager and they said they would look into it, we noted this had not been previously raised by people through surveys or meetings. We saw there were already checks in place and we did not see evidence of long wait times. The provider regularly checked call bell

times and records showed that urgent bells were answered swiftly and non-urgent call bells had been answered within five minutes. We also noted there had been low numbers of falls at the service which showed staff were able to get to people to support them, without them attempting to mobilise independently.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. We saw evidence of recruitment checks taking place before staff came to work at the service. Staff files contained evidence of work histories, references, health declarations, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carries out criminal records checks and holds a list of potential staff who would not be appropriate to work in social care. We also found that where the provider had recruited nurses, they had checked that they were registered with the Nursing & Midwifery Council (NMC).

Risks to people were assessed with plans implemented to keep them safe. Staff routinely assessed risks that people could face and implemented plans to keep people safe. Risks assessed included malnutrition, choking, falls and pressure damage to skin. Records showed risks were regularly reviewed and plans where updated when things changed. For example, one person had been admitted to the home with a pressure sore. A risk assessment was carried out and measures were introduced to treat the sore whilst reducing the risk of further pressure damage. Staff dressed and checked the sore regularly and kept photographs to monitor its healing. The person had a pressure mattress in place and staff regularly checked it was on the correct setting. The person had prescribed creams which staff applied daily. The person had input from the community tissue viability nurse (TVN) and records showed that with these interventions in place, the sore was healing.

Where accidents or incidents had occurred, appropriate action was taken to keep people safe. Staff documented any accidents or incidents and these were checked and monitored by management. Records showed that staff responded appropriately to incidents, by taking action to ensure people were safe and considering measures to reduce the risk of a similar incident occurring. Where one person had a fall whilst being supported to mobilise, staff safely assisted the person to the floor to reduce the risk of injury. The person was checked and supported to get up. The person's falls risk assessment was reviewed to identify if any further measures might prevent a similar fall from reoccurring.

Staff knew how to identify and respond to abuse. Staff had received training in safeguarding and safeguarding procedures were on display within the home. Staff were able to tell us signs that could indicate abuse, such as people becoming withdrawn or unexplained bruising. Staff knew how to raise an alert if they were concerned about anything and they knew how to whistle blow if they were not happy with how concerns were handled. Records showed that safeguarding was regularly discussed openly at staff meeting and one to one supervisions.

Good

Is the service effective?

Our findings

People told us that their healthcare needs were met. One person said, "If I don't feel well, I tell a carer and the nurse comes to check me over." Another person said, "If I didn't feel well, I would tell staff and the nurse would deal with it."

People's clinical needs were met. Care plans contained detailed information about people's medical conditions and the clinical support that they required. One person had a catheter and their care plan contained guidance on how regularly to empty or change the catheter. There was guidance for staff on symptoms that the person might have an infection and what to look for when monitoring fluid input and output. Staff kept accurate records regarding the person's fluids which meant any changes could be identified quickly. People had a monthly health check where their weight and vital signs were documented and these fed into risk assessment reviews. This ensured measures were in place to proactively identify and respond to changes in people's health. The provider carried out monthly audits of clinical needs such as weight, infections and pressure care to identify any changes, patterns or trends.

Staff responded appropriately to changes in people's health. Where people became unwell or changes were identified, staff referred them to healthcare professionals. For example, we observed a daily handover meeting and staff discussed how one person had sensitivity around their eyes and another person had a loose tooth. Staff documented this and planned to contact the GP and dentist for these two people. Daily records showed regular input from the GP and we saw evidence of people having regular check ups with their dentist and optician.

People were supported by nursing staff who were supported to maintain their clinical competencies. Nursing staff told us that they had regular clinical supervision and training. The provider employed a clinical lead and we saw evidence of regular meetings of nursing staff as well as learning sessions to ensure nurses stayed up to date with current practice. Nurses had received training in areas such as pressure sores and catheter care and we saw they had followed best practice in these areas when supporting people.

Care staff had received appropriate training and support for their roles. Staff completed an induction with a mentor who supported them to meet people and observe practice before working directly with people. The provider kept a record of all training to track whether staff were up to date in areas such as safeguarding, infection control and moving and handling. Staff had completed the Care Certificate and had opportunities to take further qualifications in adult social care. The Care Certificate is an agreed set of training standards in adult social care. Records also showed that care staff had regular one to one meetings with their supervisors. These supervision meetings were used to discuss the care that staff were providing and records showed staff had used these as an opportunity to discuss their training and development. The provider also had an appraisal scheme and records showed staff had annual appraisals where they discussed their performance and set goals for the coming year.

People received food in line with their preferences. We received positive feedback on the food that people were served and we observed people finishing their meals at lunch time. The food looked appetising and

people dined together in a pleasant atmosphere. Soft music played and people were given visual choices as food was served so that they could make an informed choice. There was a menu each day with a choice and the kitchen were also able to prepare alternatives for people. Care plans recorded what people's favourite foods were and records showed they were served these. For example, one person had a sweet tooth and enjoyed cakes and desserts. This was clearly recorded on the front of their care plan and records showed that they were regularly offered cakes and staff had identified this as a way to support the person to gain weight, as they were losing weight. People were asked each day about the food and their feedback was recorded. People also had opportunities to discuss food at residents' meetings and their care reviews.

People's dietary needs were met. A relative told us, "[Person] was losing weight so they've put her on energy drinks to supplement her food." Where people had specific dietary needs, these were clearly documented and plans were implemented to meet them. Where one person had difficulty swallowing, we saw that a speech and language therapist (SALT) had seen them and recommended soft foods and thickened fluids to reduce the risk of choking. Their care plan was updated with guidance for staff on the types of foods they could eat and the thickness their drinks needed to be. We observed staff providing food and drink to the person in line with this guidance. People were regularly weighed to identify any nutritional needs and staff kept accurate records of food and fluid intake. Staff were observed inputting accurate fluid measurements into the provider's electronic care planning system. This system then calculated people's fluid intake and informed staff of if they had reached their target for the day.

Staff gathered important information about people's needs before providing support to them. Care plans contained evidence of initial assessments that were used to gather information about people's needs and any preferences they had with regards to care or their routine. For example, one person had told staff that they wished to get up late and have a late breakfast. This had been added to their care plan and records showed they were supported to get up at the time they wished each day.

The home environment was suited to people's needs. People lived in an adapted building with corridors and doorways that were wide enough for them to mobilise around if using wheelchairs or walking aids. There was signage throughout the home, with pictures, to help people living with dementia to orientate themselves. We observed people moving freely throughout the home during our inspection.

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 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's consent was sought before staff provided care to them. People had agreed to their care plan and this had been documented. Where people were unable to consent, the MCA had been followed. For example, one person was living with dementia and staff had assessed their ability to make a decision to come and live at the home. They found the person lacked the mental capacity to make the decision as they were unable to retain or weigh up the information. A best interest decision was documented, involving relatives and healthcare professionals, which recorded it was in their best interests to stay at the home. As the decision involved restrictions being placed upon the person, application was made to the local authority DoLS team.

Good

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person said, "The carers are very good, they do anything you ask." Another person told us, "They [staff] chat to me and usually dash to me when I press my bell." A relative told us, "I see carers tweaking the residents' clothes, they wouldn't leave someone's top hanging off their shoulder."

During the inspection, we saw pleasant caring interactions between people and staff. In the morning, staff used a hoist to support someone to move from their chair to a wheelchair. Staff engaged in conversation throughout the procedure and smiled. Staff used eye contact and touch to reassure the person as they were lifted from their chair. The person was at ease and smiling as they joked with staff. In the afternoon, one person had eaten an ice lolly and some had dripped on their chin. A staff member noticed this quickly, asked permission and discreetly wiped the person's chin. The person thanked the staff member and the staff member stayed with the person engaged in conversation.

People were supported by staff who knew them well. Staff were knowledgeable about people's needs and backgrounds when we spoke with them. For example, one person used to give lectures at a local university and staff told us they called them 'the professor'. We observed staff interacting warmly with this person and discussing their working life. Another person moved abroad during their childhood and staff were knowledgeable about this and told us they enjoyed hearing this person's stories from their time there. Information about people's backgrounds was recorded in care plans and staff told us they were encouraged to read these. One staff member said, "Before I started, my mentor took me to each room to meet each resident. We read the care plans and get to know people the more we chat to them."

Staff involved people in their care. Care plans documented people's preferences and choices and people were regularly asked about these at reviews. Where people had make specific requests or choices, these had been documented. During the inspection, we saw staff offering people choices or hot and cold drinks and snacks. We also noted that people had regular meetings which were used to raise any issues or make requests. One person had developed a skill for leading these meetings and would regularly be the chair when meetings took place.

People were supported in a way that encouraged them to be independent and retain skills. Care plans reflected people's strengths and tasks that they could complete themselves. For example, one person's care plan documented that they were able to attend to their own oral care. During the inspection, we observed staff asking the person if they had brushed their teeth and they confirmed they had. Staff had documented in daily notes where people had completed tasks themselves. The home environment had a variety of drinks available for people to prepare themselves. A coffee machine installed in communal areas provided an easy way for people to prepare their own hot drinks and we observed one person doing so during our visit. The person told us that they liked the coffee that the machine produced. Having this in place enabled relatives and people to arrange their own drinks during visits which gave them more freedom to host visitors.

Staff knew what was important to people. People's care plans contained information about their

background, culture, religion and sexuality. The provider asked questions about this at assessments in order to identify any important information for staff. Records showed staff also recorded relatives and friends who were important to people and we observed relatives visiting people freely during the inspection. Relatives told us they were made to feel welcome whenever they came to the home and we observed staff chatting to a relative and preparing a cup of tea with them. People's daily notes documented where relatives had been in contact and staff were able to support people to use the telephone or internet to contact relatives whenever they wished to.

Staff were respectful of people's privacy and dignity when providing care. We observed that people looked comfortable and were dressed in clean clothes. Where staff noticed one person required some support with personal care, they were discreetly supported to move to a private area of the home where they could be supported. Staff were observed knocking on people's doors and asking permission before entering and wherever personal care was delivered, it took place behind closed doors.

Good

Is the service responsive?

Our findings

We received positive feedback regarding care planning. A relative told us, "They've really responded to how [person] is. They are very kind, they've managed her behaviour well; safely and nicely."

Care was planned and delivered in a person-centred way. People's care plans were detailed and we noted improvements to the level of detail within care plans since our last inspection. Care plans covered people's needs, their routines and preferences. Where needs were identified, detailed plans were drawn up to inform staff of how to meet them. For example, one person could become agitated during personal care. There was guidance for staff including how to address and greet the person in a way that would put them at ease. It informed staff that if the person did not want personal care, they were to come back and try again. Records showed that these interventions were working as staff had been able to provide personal care multiple times each week and records showed that the person was not distressed.

Care plans recorded what was important to people. People had been routinely asked what time they liked to start their day and when were their preferred mealtimes. Records showed that these were being fulfilled and staff were knowledgeable about people's routines when we asked them about them. One person did not like being hugged and found certain terms of endearment upsetting. This was documented on the front of their care plan and two staff told us about this separately, which showed that they had read the person's care plan and knew what was important to them. We observed staff interacting with the person in their preferred manner, which made them feel more at ease.

Changes to people's needs were responded to. Care plans contained evidence of regular reviews and the provider kept track of these to ensure reviews took place at least once a month. Staff also responded to any minor changes on a daily basis, which had been picked up within daily notes. Staff recorded multiple updates each day which recorded care tasks, activities, food intake and how the person was feeling. A staff member showed us the smartphone device used to update daily notes and how this informed staff at a glance if someone wasn't having a good day. They showed us that one person had said they did not feel well in the morning and staff had increased checks and interactions with the person as a result.

People had access to a range of activities. The home employed staff that took a lead on preparing and facilitating activities. There was a timetable on display within the home which showed multiple activities each day. Activities catered to a range of interests and included music, arts, exercise, reminiscing and themed events. The home organised regular parties and events at times such as Easter, Christmas or summer. A relative told us how one person had enjoyed a Christmas dinner, despite a deterioration in their mobility. They told us staff arranged a specialist chair and they were able to enjoy Christmas dinner with people and relatives.

Complaints were documented and responded to. A relative told us, "They took my complaint seriously, they explained everything to me and remedied it. I have no issues now." People and relatives told us that they knew how to complain and felt confident any issues they raised would be addressed. There was a complaints policy on display within the home and people were regularly asked for feedback through

reviews, surveys and meetings. All complaints had been documented and records showed these had been investigated and responded to within the timescales outlined in the provider's policy. Complaints were monitored by the provider in order to identify themes and records showed there had been four complaints in the last 12 months.

End of life care was planned in a sensitive manner. Care plans showed people had been asked about any advanced wishes they had and their preferences for end of life care. One person had a condition that could deteriorate and they would require end of life care. They had a very detailed care plan which recorded they wished to stay at the home and have relatives called if their condition deteriorated. The person had been prescribed medicines in anticipation of them requiring palliative care and staff were trained in how to administer them. We saw compliments and thank you cards from relatives expressing gratitude to staff for the way in which people had been supported at the end of their lives.

Good

Is the service well-led?

Our findings

People and relatives told us that the service was well-led. People told us they knew the registered manager. One person told us, [Registered manager] always stops to say hello." A relative told us, "[Registered manager] is very professional. She has very high standards, but is also very relaxed."

The provider regularly checked and monitored the quality of the care that people received. A variety of audits were carried out that checked areas such as health and safety, documentation, food and infection control. Records showed these audits were robust and where they identified any areas for improvement, these were added to an action plan which the registered manager used to keep track of actions and sign off where completed. For example, a recent infection control audit had identified staff had not always been signing to state where cleaning tasks were completed in the laundry. A discussion was held with staff and records had since been completed accurately.

Audits were also used to monitor clinical needs. The registered manager carried out a monthly analysis of clinical needs such as infections, weight loss and falls. These were monitored each month and a record was kept in order to identify any patterns or trends. A recent audit of people's weight had noted a person losing weight and a referral had been made to their GP and their nutrition plan had been updated to state they required fortified foods.

Staff felt supported by management. A staff member said, "If I don't understand something, they [management] help me. We all work well together and communicate as a team." Staff told us the support of the registered manager and clinical lead was good and they had regular contact with them. We saw staff working alongside the registered manager and clinical lead throughout the day and the registered manager's door was open and staff were able to access management easily. Daily handover meetings took place which management attended. We observed the handover meeting and the registered manager discussed people's needs with care staff and nurses. Staff meetings also took place regularly and staff told us they were encouraged to make suggestions.

The provider had systems to encourage staff and make them feel valued. There was a competency framework in place which staff followed. This had enabled staff to improve their own practice and identify goals to better themselves. The registered manager kept track of this and staff told us it was meaningful to them and gave them opportunities for career development. The service had recently been awarded a gold accreditation through Investors in People. Investors in People is an external leadership and management accreditation scheme. The report cited staff feeling valued and having opportunities to develop as a reason for this award.

People were involved in the running of the home. Regular meetings took place which provided people with an opportunity to make suggestions and hear about any planned changes. People took the lead on these meetings and one person helped to co-ordinate them and liked to chair these meetings. A recent meeting showed people had discussed events at the home and were planning a cheese and wine evening.

The provider had developed links with stakeholders and the wider community. People's care records showed frequent communication with stakeholders such as commissioners and social care professionals. The activity timetable showed regular activities including visits from the community. One person told us about a visit from a school which they had benefitted from and records showed that a fashion activity had been arranged with a local clothing shop which provided people with an opportunity to purchase clothes.

The provider understood the responsibilities of their registration. Providers are required to notify CQC of any important events such as serious injuries, deaths or allegations of abuse. Records showed that where required, the provider had notified CQC.