Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Ashgreen House

Sandbach Place, London, SE18 7EX

Tel: 02083317240

Date of Inspections: 23 January 2013
22 January 2013

Date of Publication: February 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Sanctuary Care Limited
Registered Manager	Mr. Phillip Smith
Overview of the service	Ashgreen House accommodates up to 52 people who have elderly nursing, residential, or intermediate care needs. Ashgreen House is located in Woolwich in south east London.
Type of services	Care home service with nursing Rehabilitation services
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 January 2013 and 23 January 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by other regulators or the Department of Health. We were accompanied by a specialist advisor.

What people told us and what we found

People using the service and their relatives we spoke with said they were receiving a good service. They were very complimentary about the staff working at the home. One person said; "I can't praise the staff enough. They do a wonderful job". Another person said; "There's usually one or two who stand out. It's the little things they do. They treat you like a proper human being". People felt comforted and safe in the home, and told us their families were involved decisions in their care.

A residents survey was completed in 2012 which showed, for example, that most respondents were happy with the care they received and that they and their family and friends had been involved in their care plan. They said their care and medical needs were attended to.

We found people using the service were treated with dignity and respect. They were protected from the risk of abuse and were cared for by staff who were suitably qualified and skilled to meet their needs. However, care was not always planned, delivered, or recorded in a way that ensured people's needs were met. Nor was care always reviewed fully after an incident such as a fall. We also found a fire safety mechanism in the home was not working.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 01 March 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement

powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People expressed their views and we observed them being involved in decisions about their care, such as choosing how to spend their time and what to have for supper. Some of the records we looked at showed people using the service and / or their relatives had been involved in drawing up people's care plans.

People who use the service were given appropriate information and support regarding their care or treatment. We observed staff taking care to provide support to people at a pace that suited them and in ways that encouraged them to be as independent as possible, for example with taking part in activities and eating supper.

People's diversity, values and human rights were respected. The home collected information for example about a person's ethnicity and religion to ensure its services were responsive to these needs. The kitchen provided Asian and Caribbean dishes, and we saw examples of work with the European Reminiscence Network which involved people using the service in a reminiscence and oral history sewing project with a cross-cultural perspective. Christian church services were held regularly at the home.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Proper steps had not been taken to ensure each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our inspection on 29 June 2011 we found action was needed to maintain compliance with this essential standard. This was because staff did not receive feedback on the incidents they reported, and nursing staff were not expected to administer basic life support in the event of a medical emergency.

At our inspection on 22 and 23 January 2013 we found incident reports were being copied back to the unit where the incident took place after the acting home manager had reviewed the report, and had put in place an action plan to minimise the risk of the incident occurring again. We also saw minutes of weekly senior staff meetings where any incidents occurring in the previous seven days were noted.

Records we saw showed that all permanent nursing staff, except the acting home manager, had completed training to enable them to be Health and Safety Executive approved appointed first aiders, and competent to attempt cardiopulmonary resuscitation.

People's needs were assessed, however care and treatment for some people were not planned in enough detail to ensure their needs were met. Care plan files we looked at demonstrated people's needs had been assessed in relation to mobility and continence management, for example. Staff we spoke with, and the daily records we looked at, indicated for the most part that these needs were being met, but the care being provided was not included in the care plan file.

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. Care plan files we looked at showed risk assessments had been completed to keep people safe, for example in relation to nutrition and pressure ulcers. We saw however that there was not a consistent approach to completing some moving and handling risk assessments, which undermined the usefulness of the tool in ensuring the level of care provided ensured people's safety and welfare.

We saw that tools used to monitor changes in people's condition were sometimes not fit for purpose or had not been completed properly. This meant that changes in a person's

condition may not be observed accurately, putting them at risk of receiving inappropriate or unsafe treatment or care. The accidents / falls 24 hour observation record did not include checks that nursing staff we spoke with considered to be standard practice, including for example observation of pupil reaction following a head injury. Some food and fluid intake charts we saw had not recorded the actual weight and volume of how much a person had to eat or drank, only stated for example that they had toast and a cup of tea. Also a repositioning chart in one person's room was being used by different members of staff to record different things, for example some staff were using the form to record when the person's continence pad had been changed.

Not all staff we spoke with were aware of the home's procedure for summoning timely and competent help in the event that a resident collapsed and their heart stopped. The acting home manager told us that a member of staff finding someone in this position should activate the emergency alarm which would bring an approved first aider to the scene. Not all staff we spoke with told us they would activate the emergency alarm if they found someone who had collapsed or was not breathing.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

At our inspection on 29 June 2011 we found action was needed to maintain compliance with this essential standard. This was because the home had not taken adequate steps to ensure staff and others involved in running the home, were not able to benefit financially or gain inappropriately from a person using the service.

At our inspection on 22 and 23 January 2013 we found the home had a gifts, hospitality and wills procedure in place. Staff we spoke with knew that they were not allowed to accept gifts from people using the service or help them draw up their wills; nor were they allowed to witness wills or be a beneficiary.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Safeguarding vulnerable adults policies and a procedure for reporting and recording incidents were in place. Staff had received safeguarding training. Staff we spoke with understood the signs of abuse and were familiar the reporting procedure. They were aware of their professional duty to report any concerns they had about people being put at risk.

The provider responded appropriately to any allegation of abuse. Records we looked at showed allegations of abuse had been reported to the Care Quality Commission and that the provider had investigated allegations of abuse in line with local policies and procedures and in cooperation with the local safeguarding authority.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider had not taken steps to provide care in an environment that was adequately maintained. Each bedroom door within the home was fitted with a hold open device designed to deactivate automatically on the operation of the fire alarm so that the door closed and acted as a barrier to fire and smoke. We saw that some bedroom doors were propped open with wedges or chairs and staff told us this was because the hold open device was not working. They also said that some people using the service wished to keep their bedroom doors open.

We informed the acting home manager about this risk to people's safety. He told us the home needed to purchase door guard plates to resolve the problem, and that care plans would be put in place to support those people wishing to leave their doors open. We were not able to assess the impact of these measures.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development. There was a programme of mandatory refresher training for staff including, for example health and safety, moving and handling and infection control. We saw records were kept of when staff had last completed refresher training and when their next training was due. Staff we spoke with said they received the training they needed to keep their skills and knowledge up to date. They also said they received regular supervision and an annual appraisal, and records we saw supported this.

We had received information from the Nursing and Midwifery Council that the provider had allowed a nurse to work at the home with a lapsed registration. We saw that this had been rectified and that it had been an oversight on the part of the nurse and an isolated failure in the provider's system for ensuring nurses did not allow their registration to lapse.

Staff were able, from time to time, to obtain further relevant qualifications. Staff we spoke with said they were encouraged to study for higher level qualifications in care. We also saw that staff had received further training relevant to their role, for example tissue viability and diabetes.

We saw there was an induction programme for newly appointed staff to familiarise them with the home and to equip them with the knowledge and skills they needed to carry out their role.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health and safety of people who use the service.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There was evidence that systems were in place to monitor the appropriateness and safety of the care and treatment people using the service received. For example we saw the acting home manager had completed night inspections and medication and care plan file audits. We saw the audits were in depth checks that sampled records in different parts of the service and that remedial actions had been put in place. Senior staff we spoke with told us one recent outcome of this work was the improved quality of treatment and care plan files in the nursing and intermediate care units, and we saw this reflected in the care plan files we looked at.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Records we looked at showed there were regular residents meetings held in each unit of the home to involve people in the running of the unit and to get their feedback on the service being provided. There was also a residents' representative who attended the home's weekly senior staff meetings to put forward the views of people using the service. One example of people's views being acted on included changes to when breakfast and lunch were served after people had said there was too short a space of time between them. Also, people had been consulted when the home changed how services were organised so that the nursing and rehabilitation units were brought together on to the same floor. The home had ensured people kept their room number when they changed floors, as they had requested.

There was evidence that learning from incidents did not always take place and that appropriate changes were not always implemented. The incident reports we looked at showed that some actions that had been identified to prevent an incident from recurring, such as a fall, had not been implemented. For example, with respect to one incident we saw that a falls risk assessment had not been reviewed as planned. With respect to another incident we saw the same remedial action was put in place again when a person fell a second time, although it had not proved effective in preventing the person falling again after the first time.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At our inspection on 29 June 2011 we found action was needed to maintain compliance with this essential standard. This was because entries made by staff in the daily records of people's treatment, care and support were not always referenced back to the care plans.

At our inspection on 22 and 23 January 2013 we found the home had changed the care plan documentation it used and staff were not required to reference their daily records back to the care plans.

Some people's personal records were not fit for purpose. Some care plans we looked at did not provide enough detail about how each of an individual's needs should be met, for example in relation to one person's catheter care, and another person's skin integrity care and need to gain weight. The lack of proper information put people at risk of receiving care that was inappropriate. One of the members of staff who drew up care plans told us there was not enough room on the care plan document to write a detailed care plan.

We informed the acting home manager about the care plans we had seen that were not sufficiently detailed. He told us that there had been an error in the way the care plan documentation had been used.

Some of the do not attempt resuscitation (DNAR) orders we looked at were not completed fully. For example, a summary was not recorded of the communication with the person about the decision, or with their relatives, friends or an advocate where this might have been considered appropriate, for example where the person had dementia. Senior staff we spoke with told us such omissions invalidated the order. The lack of proper information on DNAR orders put people at risk of receiving unnecessary or inappropriate treatment.

Not all records were kept securely and some records could not be located promptly when needed. We observed people's personal records in current use were kept securely in lockable cabinets or in areas and offices where staff were present. However, we found a box of personal records for archiving in an unlocked activities room. A member of staff took the records to a locked cupboard for archived records when we pointed this out to

them.

We saw that a cupboard where archive boxes of records were kept was also used to store supplies. The archive boxes were not easy to reach and labels were not visible on some of the boxes. This made it difficult to locate an archived record promptly.

Some records we asked to see as part of our inspection, for example training and audit records, were readily available. However, staff we spoke with could not locate DNAR order forms promptly, which meant there was a risk that emergency treatment was delayed or that a person using the service received unnecessary or inappropriate treatment. DNAR order forms were not consistently found at the front of the person's care plan files that we looked at, nor did they have a red border to make them more easily identifiable, as was the home's policy.

Records had not been destroyed securely after they had been kept for the appropriate period of time. The provider had a procedure relating to how long records must be retained for, for example care plans should be retained for three years after the person has left the service. Senior staff we spoke with told us arrangements were in place for the confidential destruction of records past their retention date, but that no records had been destroyed since the home opened in 2004. This meant the provider may have been holding excessive and irrelevant personal information about people.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Some people's care and treatment were not planned in detail to ensure their needs were met. Moving and handling risk assessments were not completed consistently. Tools used to monitor people's condition were sometimes not fit for purpose or had been completed incorrectly. Not all staff were aware of the procedure for summoning timely and competent help in an emergency. Regulations 9(1)(b)(i)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: Some hold open devices fitted to bedroom doors were not working. This meant some doors were wedged or propped open and so would not close automatically on the operation of the fire alarm to act as a barrier to fire and smoke. Regulation 15(1)(c)(i)
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Following an incident, such as a fall, changes to people's care to manage the risks to their health and safety were not always implemented, or the change that was recommended had been shown previously to be ineffective. Regulation 10(2)(c)(i)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Some care plans did not provide fully accurate information about how people's needs should be met. Staff could not locate do not attempt resuscitation (DNAR) orders promptly, and some orders were not completed fully. Regulation 20(1)(a) Some records had been kept past their retention date. Regulation 20(2)(b)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 01 March 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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