A Cox and Mrs Z Cox

Ashleigh Nursing Home

Inspection report

17 Ashleigh Road
Leicester
LE3 0FA
Tel: 0116 2854576
Website: www.ashleighnursing.co.uk

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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?	**Requires Improvement**

Overall summary

This inspection took place on 15 December 2014 and was unannounced.

Ashleigh Nursing Home is registered to provide nursing and residential care for up to 21 older people, some of whom are living with dementia. At the time of our inspection there were 21 people using the service. The service is a converted Victorian building with accommodation on two floors and a passenger lift for access.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were able to tell us what action they would take should they believe somebody was being abused and were aware of the provider's policies and procedures, which included whistleblowing.

People we spoke with who used the service were satisfied with the care and support they received as was a visitor

Summary of findings

who was visiting their relative. We saw staff supporting people and offering reassurance when they became anxious. Staff told us and our observations showed that there were sufficient staff on duty to meet people's needs.

People were supported by staff who had been checked as to their suitability to work with them. They had undergone an induction and had received training relevant to the needs of people in their care to ensure people received the appropriate care.

Staff we spoke with had a good understanding of people's needs and knew the support and care they required. People's assessments and plans of care had been regularly reviewed and provided clear guidance for staff as to the needs of people and their role in delivering the appropriate care and support. People's medication was managed safely.

Staff had an awareness of legislation which promoted the rights of people and worked in accordance with legislation. This meant people were supported by staff to make day to day decisions as to their care and support. People in some instances had made advanced decisions as to their wishes should their health deteriorate.

We observed staff sitting with people and conversing with them about issues which were important to them. One member of staff sat talking with someone about a book they were reading. Photographs of recent events and activities in the service were on display, which included photographs of people holding a range of animals which had been brought into the service by an external organisation.

People's health and welfare was promoted and they were referred to relevant health care professionals in order to meet their health needs. People at risk of poor nutrition and hydration had assessments and plans of care in place for the promotion of their health and well-being.

The provider, registered manager and staff had a clear view as to the service they wished to provide which focused on a homely and caring environment for people. Staff were complimentary about the support they received from the management team. However, we found that there were limited arrangements for the management team and staff to review their practices as staff meetings did not take place regularly. This could impact on the service and the support and care people received.

Monitoring systems were in place to check the quality and safety of the service provided. However where shortfalls were identified, we found that there was not a clear audit trail to evidence whether improvements had been made.

Systems for seeking the views of people who used the service and their relatives were in place. However, people's views were not collated and used to develop the service nor were they shared with people and other stakeholders, such as relatives of people using the service and health and social care professionals. This meant that people could not be confident that their views had been listened to or acted upon.

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?

Good

The service was safe.

People who used the service and a visiting relative told us they felt safe with the support provided by the staff.

Staff demonstrated a clear understanding of what abuse was and were aware of their role and responsibilities to report incidents and any safeguarding concerns.

Risks to people's health, safety and well being had been identified, assessed and managed in an appropriate way.

There were sufficient numbers of staff available to keep people safe. Staff had been appropriately recruited to ensure they were suitable to work with people who used the service.

People's medication was stored and administered safely by nursing staff.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate knowledge and skills to provide care.

Staff had an awareness of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005, which had been put in practice to ensure people's human rights and legal rights were respected, This meant people were involved and consented to their care and support.

People at risk of poor nutrition and hydration had assessments and plans of care in place for the promotion of their health and well-being.

People were referred to the relevant health care professionals in a timely manner which promoted their health and well being.

Is the service caring?

Good

The service was caring.

People we spoke with and a visiting relative told us the staff were kind and caring and looked after people well. Staff we spoke with were aware of the needs of people and we observed staff providing reassurance when people became anxious.

People's plans of care contained information about their likes and dislikes and these were known by staff we spoke with. People's records included information where they had made decisions about aspects of their care when they became unwell.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People received care and support that reflected their assessed needs.

People had access to a complaints procedure. We found the service had received one complaint during the year.

People had the opportunity to take part in activities of their choice organised by the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider, registered manager and staff had a clear view as to the service they wished to provide which focused on a homely and caring environment for people. Staff were complimentary about the support they received from the management team.

Staff were supervised so that people who used the service had their needs met. However the management team and staff did not have regular meetings. This meant that opportunities to share information about the service and practices were restricted.

Monitoring systems in place to check the quality and safety of the service were not always effective in that they were not reviewed or shared with people using the service or their relatives or other professionals involved.

Ashleigh 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 15 December 2014 and was unannounced.

The inspection was carried out by two inspectors.

We spoke with four people who used the service and spoke with a visitor who was visiting their relative.

We spoke with the provider, the registered manager, a nurse and four care staff.

We pathway tracked the care and support of three people, which included looking at their plans of care to check that they were receiving the care they needed. We looked at staff recruitment and training records. We looked at records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

We contacted commissioners for health and social care, responsible for funding some of the people to live at the home and asked them for their views about the service.

We looked at information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that providers must tell us about.

Good

Is the service safe?

Our findings

One person we spoke with told us "I feel safe."

A visitor we spoke with who was visiting a relative told us "I've never seen anything horrible, [relative's] safe here."

Staff told us how they supported people in staying safe Staff we spoke with told us "I really feel people are safe here", when speaking of the environment staff said "The hygiene is good," and "Every single door is alarmed and people are looked after properly." External doors were alarmed which alerted staff to people entering or leaving the building. The front door was fitted with a keypad entry system, which was code sensitive. People living at the service would need to be supported to leave the service by staff to ensure their safety.

We spoke with members of staff and asked them how they would respond if they believed someone using the service was being abused or reported abuse to them. Staff were clear about their role and responsibility in reporting their concerns and were aware of their role in the promoting of people's choices and rights. No safeguarding concerns had been identified by the service.

We looked at peoples' plans of care and found appropriate individual risk assessments had been undertaken and had been regularly reviewed. These covered a range of topics which included, the use of bed sides and an air mattress to reduce the risk of the development of pressure sores. One person had a special type of bed which could be positioned to promote the person's breathing. This showed that where risks had been identified, plans of care had been put put in to place which provided information to staff on how to keep people safe and promote their health and well-being.

People's safety was supported by the provider's recruitment practices. We looked at staff recruitment records for staff, which included nurses. We found that the relevant checks had been completed before staff worked unsupervised at the service, which included a check as to whether nurses were registered with the appropriate professional body.

We found there were sufficient staff on duty to meet people's needs. Staff told us "There's enough staff and we call in more if needed, there's very little agency, our own staff will come in."

The nurse told us that people's medication was regularly reviewed with health care professionals. People's medication administration records showed that when people had had their medication reviewed any changes was quickly acted upon by the service, which meant people's health was being promoted and changes were managed in a timely manner.

A member of staff we spoke with told us "We are very good at using diversionary stuff instead of medication to help people who can be challenging." This meant people were supported by staff when they become distressed or anxious by talking with them or using some other form of distraction, instead of using medication as the first option.

We spoke with the nurse about the use of PRN medication (PRN medication is administered as and when needed), we found that the nurse had a good understanding as to when PRN medication was to be administered. For example the use of medication to help somebody when they became agitated or when they were in pain. The nurse was able to tell us how one person displayed anxiety and how another person expressed pain through facial expressions. However, we found there to be potential that people may not be administered PRN medication consistently as there were no written protocols in place specific to people using the service for staff to follow. We brought this to the attention of the nurse who said they would develop a protocol for each person's prescribed PRN medication.

We looked at the medication and medication records of three people who used the service and found that their medication had been stored and administered safely. We looked at the records and storage of two controlled drugs and found there to be an accurate record. (A controlled drug is one whose use and distribution is tightly controlled because of the potential for it to be abused.) This meant people's health was supported by the safe administration of medication.

Good

Is the service effective?

Our findings

Staff we spoke with were able to provide a good insight into the needs of people using the service and told us training had helped them to provide the appropriate care. A staff member told us "I've had my core training and I'm doing my National Vocational Qualification (NVQ) level 3 in health and social care." Staff records showed staff had received training which supported them in delivering effective care.

Staff told us about their induction, A staff member told us "I had a good induction, I did three 'shadow shifts' (worked alongside an experienced member of staff), had a police check and had an interview." A second staff member told us, "When staff started they do a paper induction then shadowing for different shifts, all the checks are done first before they start."

A Deprivation of Liberty Safeguard (DoLS) assessment and authorisation is required where a person lacks capacity to make a decision and needs to have their freedom restricted to keep them safe or to have their needs met. The registered manager told us that there were two people who used the service that had an authorised (DoLS) in place, which had been granted by a 'Supervisory Body'. We looked at their records and found that the provider was complying with the conditions where these had been applied by the 'Supervisory Body'.

One person's record included information about an 'independently paid advocate', who was supporting a person to obtain an item of equipment. They told us "I have a chap who visits me he's helping me with a wheelchair."

One person's records contained information about their choice to make an advanced decision about their care with regards to emergency treatment and resuscitation. This showed that people's choices and decisions were supported and acted upon.

We spoke with the provider and registered manager about the Mental Capacity Act (MCA) 2005 and (DoLS) and what they meant in practice for the people who used the service. They were knowledgeable about how to protect the rights of people who were not always able to make or communicate their own decisions. People's plans of care showed that the principles of the MCA had been used when assessing people's ability to make decisions

We asked people for their views about the meals provided, they told us "We get nice cups of tea and milk and juice when we want one. Sometimes the dinner is okay," and "You get a fair amount to eat." A visiting relative told us "They make sure she's [person using the service] fed well."

People's records included nutritional assessment tools, to identify those people at risk of poor nutrition and dehydration. Where a risk has been identified a plan of care had been developed, which required staff to complete charts to record people's food and fluid intake. We found that these records were being completed, however there was no evidence as to how this information was evaluated and used. We spoke with the nurse on duty who told us they would review people's care records to include information about the volume of food and fluid intake each person should have and information about what action should be taken should the person not eat or drink sufficiently.

The chef showed us information they had about people who required specialist diets. This included people who required a 'soft' diet and people with diets tailored to meet their health care needs such as diabetes. The chef was aware of the likes and dislikes of each person and the menus reflected a diet to meet people's needs. The chef showed us the food supplies held within the kitchen, which included a range of fresh fruit and vegetables, frozen meat and dried goods. The chef told us that the meals were home cooked, and used ingredients to support and promote people's health, for example by the use of full fat milk.

A person's care plan showed they had been assessed as requiring a 'soft' diet due to the risk of choking and that a referral had been made for them to be further assessed by a Speech and Language Therapist (SALT). The recommendations from the SALT team had been developed into a care plan, which included the use of 'thickeners' in drinks to reduce the risk of choking. Our observations of the lunchtime meal and discussions with staff showed that people's plans of care were being followed by staff.

We observed people eating their lunchtime meal. People had the choice of home made soup and sandwiches and cake for dessert. People were supported by staff in the eating of their food.

Good

Is the service effective?

Staff each day asked people what they wished to eat from the menu, the menu was compiled with the involvement of people using the service. Information as to people's likes and dislikes were included within their records.

People's care records showed that people were supported by a range of health care professionals, which included GP's, speech and language therapists and psychiatrists, which promoted people's health and wellbeing.

Good

Is the service caring?

Our findings

People we spoke with shared with us their views about the care and support they received. One person said “They are not bad the staff, they are kind.” We saw examples of kind and attentive staff supporting people gently and with dignity during our inspection. It was clear that all staff knew the choices and preferences of the people that they were supporting.

A member of staff was seen sitting with someone who was distressed, gently rubbing the person’s arms and hands and talking calmly with them. Another member of staff was seen sitting with a someone who was being cared for in bed, stroking their hair and speaking softly with them. The support provided by staff reassured the people involved and provided comfort.

We saw people being supported to attend to their personal needs with sensitivity which promoted people’s privacy and dignity. A majority of the rooms were shared occupancy and curtains were provided to promote people's privacy was personal care was being delivered.

A visitor told us “It’s a nice place, the staff are friendly.” Staff we spoke with told us “We give really good care here, and the staff really do care. If the people want anything we do it,” and “It’s lovely here, it’s dead friendly and easy to get on with everybody. It’s homely here, not clinical.”

People were involved in decisions about their care and support. People’s plans of care provided information about people’s likes and dislikes and staff we spoke with told us how they involved people in the development and review of people’s care records. “I talk to people about their care plans and I involve their relatives where I can.” People’s preferences about their care and support were recorded within their plan of care.

Good

Is the service responsive?

Our findings

A person we spoke with told us "They get things for me in reasonable time."

We saw someone who became anxious being supported by staff to go outside for a walk. Staff told us that this helped the person to reduce their anxiety and we observed that this was the case. A second person who became unsettled in the dining room at lunch time due to the level of noise was supported to eat their meal in a quieter area.

Assessments carried out by social workers prior to people moving into the service was in place and had been used to develop plans of care. The plans of care described people's routines and how to provide both support and personal care. Staff we spoke with were knowledgeable about they people they supported and were able to tell us about their needs.

People in some instances required additional monitoring due to their health needs. For example people being cared for in bed were at risk of the development of pressure sores and this was highlighted in people's plans of care. Staff followed people's plans of care and brought to the attention of the nurse on duty concerns regarding people's skin integrity to ensure people's health was promoted.

People's records showed that people were on occasions involved in activities. These included one to one conversations with staff, hand massages and a recent visit by an organisation which had brought a range of animals into the service for people to handle and look at. The service had also recently held a Christmas party to which relatives and friends were invited. Staff told us that they engaged people in activities regularly. A staff member told us "We do stuff with people all the time. Nails and singing."

A person moved into the service on the day of our inspection. Staff we spoke with were aware of the person's needs as they had read their plan of care and records. We also found that the chef had received information about the person's dietary needs. This showed that the service was able to respond to the person's needs upon their admission and provide the support they required.

Many of the bedrooms in the service were shared rooms for two people. We spoke with the provider and registered manager about how people were supported to make choices about who moved into their room with them. The registered manager told us that before moving into Ashleigh Nursing Home people were encouraged to visit and look at the room and talk with the person who they might be sharing with. However records did not include information about discussions between people considering moving into the service and those already in residence, nor was there a system by which people could review their decision and be supported where they requested a change not to share a room, unless a vacancy became available.

The service had received one complaint for the current year and the provider told us they had spoken with the person about their complaint. However there was no record to confirm their discussion with the complainant or whether the complainant was satisfied with the outcome. We spoke with the provider and registered manager about the documentation of complaints. They told us they would develop a form for the recording of people's concerns, along with the outcome and the information provided to the complainant in response to the issues raised.

The provider and registered manager told us they had an 'open door policy' which meant relatives or friends of people who used the service could speak with them openly about any issues. The provider told us of their intention to develop a 'resident support group', involving people who use the service and their relatives. We saw on the notice board an invite for a coffee morning to establish the setting up of this group.

Requires Improvement

Is the service well-led?

Our findings

We asked the provider how they could evidence that they provided a good service. They told us that they had received cards from relatives and friends of people who used their service, thanking them for the care staff had provided. We found cards contained positive comments about the service, such as 'I would like to say thank you to all of you for all the wonderful care that you have given to my most dearest friend.' And 'thank you for your endless care towards [relative]. We won't forget what you did.'

The provider told us that they had recently been audited by commissioners for both health and social care who had identified that the service was meeting their expectations. We contacted representatives from commissioners who told us they were satisfied with the service provided by Ashleigh Nursing Home.

The provider told us that the team worked together collectively to provide good quality care, stating that the vision and values of the service were "to provide a homely and safe environment, where people feel secure."

The provider told us over the next twelve months plans were in place for the further development of the service for people who had dementia. They told us they had plans for the development of features which included a 'Muriel freeze' on a lounge wall to provide stimulation and the development of the garden to increase sensory stimulation.

The registered manager told us of their plans for the future development of the service through staff development with an emphasis on dementia care. They told us they had had discussions with the provider about increasing the number of days they spent focussing on the day to day running and management of the service as opposed to delivering nursing care, to ensure the service was managed effectively. The provider confirmed they were looking into the feasibility of this.

We spoke with staff and asked them for their views about the management and leadership of the service. They told us "The managers respond well, they are quick, they are good like that," and "If there's a problem the managers respond quickly." Staff told us they were supervised by the manager, which included observational supervisions of their work practices. A member of staff said "I've had my supervisions, every other month, and we do have staff meetings."

Records showed one staff meeting had taken place earlier in the year, this frequency meant that staff had limited opportunities to discussed the service together. The minutes of the meeting showed that staff had been given instructions on the need to complete people's records in a timely manner. In addition staff had been asked to ensure they provided both group and individual activities. However there was no evidence that this had been monitored by the provider or registered manager to ensure there instructions had been acted upon and whether it had had a positive impact on people using the service.

We saw that people who used the service and their relatives had completed surveys which sought their views about the service provided. A number had been returned and were mostly complimentary. However we found no evidence that the information had been collated or used to produce to a report to share with people who used the service and others detailing what actions the provider intended to take in response to people's comments.

A number of quality of care audits and health and safety audits had been carried out with regards to the safety and integrity of the building, both internally and by external providers. The provider and registered manager were able to tell us what actions they had taken to address any shortfalls identified, however the actions taken had not been recorded. We saw there were systems in place for the maintenance of the building and equipment and to monitor the safety of the service. This included maintenance of essential services, which included gas and electrical systems and appliances along with fire systems and equipment.