April Rai Limited

Ashville House

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

This announced inspection took place on 25 July 2018. The service was last inspected in February 2016 when it was rated good. We found the service had maintained its good rating across all areas.

Ashville House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashville House accommodates three people in an adapted terraced house. People living in the home had mental health needs.

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.

The provider had systems in place to ensure people were safeguarded from abuse and avoidable harm. There were robust risk assessments in place and people's medicines were managed in a way that ensured they received them safely. There were enough staff who had been recruited in a way that ensured they were suitable to work in a care setting. The home was clean and free from mal-odour. When incidents occurred the provider took action to prevent recurrence and ensured lessons were learnt.

People's needs and choices were assessed and care plans focussed on developing skills and independence. Staff received the training and support they needed to perform their roles. People told us they liked the food and we saw people were supported to eat a varied and nutritious diet. Staff worked with other organisations and healthcare services to ensure people's needs were met. Adaptations were made to the building where this was required to meet people's needs. People were supported to make their own decisions and the service was working within the principles of the Mental Capacity Act 2005.

People told us the staff were kind and compassionate and we saw positive interactions between staff and people living in the home. People's relationships, religious beliefs and cultural background were taken into account and people received support that reflected their beliefs and cultural background. People's privacy was respected and they told us their dignity was respected.

People received personalised care and records showed people's care plans were updated when their needs changed. People were supported to attend a range of activities of their choosing. People knew how to make complaints and there was a clear system in place for responding to complaints. The provider had policies in place to ensure people received appropriate end of life care should the need arise.

People and staff spoke highly of the registered manager and told us she demonstrated person centred values. There were clear systems in place to ensure the quality and safety of the service were maintained. The provider and registered manager had a plan to ensure the service was sustainable and stayed up to

date with best practice guidance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

Ashville House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by one inspector on 25 July 2018. The provider was given 48 hours' notice as the service is a small care home where people are often out during the day; we needed to be sure people would be in during the inspection.

We used information the provider sent us in the Provider Information Return. 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 also reviewed information the provider had submitted to us in the form of notifications. Notifications are events and incidents that providers are required by law to tell us about. We also sought feedback from the local authority monitoring team who visited the service.

During the inspection we spoke with two people who lived in the home and two staff members including the registered manager and a support worker. We reviewed two people's care files including needs assessments, care plans, records of care and reviews. We reviewed two staff files, including recruitment, supervision and training records. We also reviewed various meeting minutes, policies, documents and record relevant to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. One person said, "I feel very safe." Another person told us, "If I was scared or unhappy I'd complain, I'd tell [registered manager] and she would sort it out." Staff knew how to identify signs of abuse and knew how to report allegations to the appropriate safeguarding authorities. The provider's safeguarding policy was clear about how to report concerns and the local contact information was on display in the office. There had been no safeguarding concerns since our last inspection. The systems were in place to ensure people were safeguarded from abuse.

Care files contained risk assessments where risks had been identified during the assessment and care planning process. These contained clear information about the steps staff should take to mitigate risk. They also considered the rights of people to take risks in their lives. For example, one person was identified as being at risk of falls but staff established this risk was increased if they insisted the person used mobility aids supplied as the person did not like the mobility aid. Therefore, staff were given guidance about how to support the person to mobilise without using the equipment. Risk assessments were reviewed regularly and updated when people's needs changed.

Staffing levels at the service were set with one member of staff on duty at all times, with the registered manager available for additional support during office hours or when required. People told us there were enough staff available and they did not have to wait to receive support. Recruitment records showed the service had continued to follow robust recruitment processes that ensured staff were suitable to work in a care setting. The application process included exploring staff members values to ensure they matched with the organisation.

People told us they received support to take medicines. One person said, "I get help with my tablets three times a day. They make sure it's OK." Another person told us, "They help me with my tablets." Records showed there was clear information available to staff about the nature and purpose of medicines prescribed. We noted medicines for one person were supplied in a way that meant prescription instructions were not being followed. This person was prescribed some medicines to be had before food, and some after food but they were supplied in the same container and could not be separated into different doses. The registered manager contacted the pharmacist and arranged for medicines to be re-dispensed so they could be administered before and after food as prescribed. Staff competency for administering medicines was assessed annually and clear records showed when people had been supported to take their medicines.

The home was clean and free from malodour during our visit. People were supported to keep their bedrooms clean and tidy with staff completing checks as part of people's care plans where this was appropriate. Staff cleaning duties were included as part of the daily handover and routine checks of hygiene were carried out. Personal protective equipment was available to ensure risks of infection and cross contamination were mitigated.

We reviewed incident records and saw that action was taken to prevent incidents recurring. Where necessary care plans and risk assessments were updated following incidents. The provider recorded

meetings with people to discuss incidents after they had occurred. These showed people were encouraged to think about to consequences and how incidents could be prevented going forward. Incidents were discussed in staff meetings and supervisions to ensure learning was shared across the staff teams.

Good

Is the service effective?

Our findings

One person had moved into the service since our last inspection. We saw the provider had worked with the referring agency and hospital where they had been receiving treatment to complete a comprehensive assessment of their needs before they moved in. A staff member said, "We had a lot of information before they moved in. They [referrers] made their needs seem very high, we expected things to be a lot more challenging than they were. [Person] settled in really well and we haven't seen any of the behaviours they saw regularly in hospital." The person had been as involved they were able in their assessment, and their views on their support were reflected throughout the plan. For example, staff were given clear guidance on how to respond to the person's delusions and hallucinations in a way that minimised the risk of causing distress and agitation. Before people moved in they completed a gradual transition to the service where their reaction to the new setting was monitored and any concerns were escalated to appropriate healthcare professionals.

Staff told us they received regular supervision and this was confirmed by records. We saw staff were supported to discuss the needs of people they supported, as well as their performance in their role. Staff completed assessed online training courses in areas relevant to their role. As the service supported people with mental health needs, staff had all received training in mental health conditions. A member of staff told us they had attended a conference to help develop their understanding. They said, "I went to the Dementia 20:20 conference which was really good. The registered manager recommended it. It was really helpful. [Person] has the early stages of dementia and it really helped me to understand his mood swings."

People told us they liked the food. We saw people were asked what they wanted to eat before meals, and were involved in preparing snacks and drinks where they wished and were able to. One person joked, "I get on alright with the food. Most of the time the staff do it. No one has died of food poisoning yet!" Care files contained details of people's dietary preferences and records showed people were supported to eat in line with their preferences. For example, a house meeting recorded, "[Person] would like more meat pies." Records showed they were regularly supported to eat meat pies.

During the inspection we saw staff contacted people's social workers to follow up on actions agreed at review meetings. This was to ensure one person was able to make progress with the goal identified during their review. Records showed where people accessed other services, such as local support and social groups, staff liaised with each other to ensure people received the support they needed to engage. This meant the service was working with other organisations to ensure people received effective support.

People told us they were supported by staff with both their physical and mental health needs. One person said, "Staff help me stay on top of things. If I'm unwell they take me to the hospital or to talk to someone." Care files contained clear information about people's healthcare needs and staff maintained records of the information and advice given at health appointments. Where people needed support to follow the advice of healthcare professionals this was incorporated into their care plans. We saw staff were supporting one person to develop their understanding of a recent diagnosis in a kind and sensitive manner.

The premises was an adapted terraced house that was suitable for people's needs. People told us they had chosen the decoration of their bedrooms, and house meeting minutes showed people had recently got new furniture to meet their needs. Where people needed adaptations, such as specialist toilet facilities these had been provided.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had been assessed as lacking capacity to consent to their care and treatment. Records showed appropriate best interests decision making with regards to their placements. They were also subject to a DoLS which had no conditions attached. Records showed the other people living in the home had been consulted about installing a lock on the front door for this person's safety as it affected them as well. The house meeting minutes captured the other people appreciated the need to keep their housemate safe, and declined the offer of having a key.

People told us they were offered choices and were not restricted. One person told us, "I can go out when I want, and I can do what I want." Another person said, "I make my own choices. I go out by myself, but I'm also happy for staff to come with me." Staff demonstrated they understood how the MCA applied to people living in the home. One staff member explained, "[Person] needs support for all decisions, we have to frame it for them. If it's just open choice they get stuck but if we offer a choice of two things they can decide."

Good

Is the service caring?

Our findings

One person told us, "I like the people and the staff. The staff stop me from feeling suicidal. They ask me how I am feeling. They are very nice. The staff are good people." Another person said, "The staff are kind. They care. They are doing a good job. This place really feels like home." During the inspection we saw staff were polite and encouraging to people, and there was a relaxed atmosphere where people joked and laughed with the staff throughout the day.

Care files contained clear information about how people expressed their emotional needs, and provided guidance for staff on how to respond to ensure people felt valued. It was emphasised that people's needs meant they sometimes say things that were not true, or did not reflect reality but staff should respond to the intent and tone of conversation to ensure people's emotional needs were met.

Staff emphasised the importance of developing trust with people in order to build strong, compassionate relationships. One staff member explained, "When [person] moved in it was clear they were scared. They fought the support, they were worried we'd put tablets in the food, so we'd taste it to show it was ok. Gradually they understood we weren't trying to hurt them and now it's good." Staff demonstrated they understood how people's presentation varied. For example, a staff member said, "With [person] when they are saying they are in pain, or they are angry really they are probably ok but want you to spend time with them. When they are quiet, not expressing themselves, that is the time to worry. That is when you put the detective hat on and try to find out what is wrong."

Care plans contained information about people's religious beliefs and how they chose to express their faith. People were asked about their significant relationships and the support they wanted to receive to maintain relationships. None of the people living in the home had chosen to disclose their sexual orientation, but the service asked about this in a sensitive manner during assessments and reviews. This meant the service was making efforts to ensure people felt comfortable to disclose their sexual identity to staff.

People told us staff respected their privacy. One person said, "We get privacy. They [staff] always knock on the door. They check there's no one in the bathroom before they go in." Care plans contained guidance for staff on how to maintain people's dignity and included that people's independence with intimate care should be promoted and encouraged.

Good

Is the service responsive?

Our findings

People told us they were involved in meetings about their care and this was confirmed by the review meeting minutes viewed. We saw people were asked for their views of their support and were involved in making changes or future plans. For example, one person was planning their holiday abroad. Care plans were personalised and reflected the individual needs and preferences of people living in the home. Staff maintained clear records of the support and care they provided. These showed people received care as described in their care plans.

Staff were sensitive to the changing needs of people living in the home. A member of staff explained, "[Person] is no longer confident going out by themselves. They worry they will get lost, but they aren't quite ready to ask for support. So they'll start talking about the shops and I'll say 'oh, I need to pop to the shop too, let's go together.' That way they still do things, but don't get frustrated or feel embarrassed that they can't do it by themselves anymore."

Records showed people were supported to attend a range of activities of their choosing. Sometimes people attended activities as a group, such as a recent trip to the seaside. One person told us they had enjoyed this trip very much. Records showed people were also able to go on activities individually if they wished.

People told us they knew how to make complaints. Both people told us they would raise any concerns they had with the registered manager, and they were confident she would take steps to resolve any problems. The provider had a complaints policy which included information about the expected timescales for response and how to escalate concerns if people were not happy with the initial response. The service had not received any complaints since our last inspection.

People were encouraged to provide feedback and raise issues during regular house meetings. We saw one of the people living in the home wrote the minutes of the meeting. They told us they liked doing this. When people made suggestions, such as menu changes, or activities to try, records showed these were completed.

No one living in the home was identified as being in the last stages of their life. However, staff recognised the importance of seeking people's views about their end of life care in advance. Records showed people were regularly asked about their views in a sensitive way and information as captured and updated into care plans as and when people expressed it. One person had recently received a potentially life-changing diagnosis and we saw staff were taking time to explore their understanding of their diagnosis. The provider recognised the importance of ensuring effective planning to ensure people were able to receive the support they wanted at the end of their lives.

Good

Is the service well-led?

Our findings

People told us the registered manager was kind and treated them well. One person said, "[Registered manager] is a nice lady." Staff told us the registered manager promoted person centred values. They said, "[Registered manager] helps us. She wants to help people. She helps everyone that's why it's the way it is here. We all like to help."

The provider gave everyone who lived in the home a service user guide. This emphasised the service was driven by core principles of supporting people to live the best lives they could, and engage their full human and citizenship rights. Individual choice and control over their lives was emphasised. These principles were reflected in staff meeting minutes where staff discussed individual people living in the home and how to ensure they were being supported to have their choices respected.

There were clear systems of checks and audits in place. The staff on duty completed regular health and safety checks and the registered manager and nominated individual completed additional audits to ensure the quality and safety of the service. Records showed where actions were identified through audits these were completed in a timely manner. For example, where maintenance had been required this was completed.

People were given regular opportunities to feed into the development and activities of the service through house meetings. In addition, the provider completed annual satisfaction surveys. These showed people were happy with support they received. The service also sought feedback from professionals involved in supporting people to ensure they were involved in the development of the service. The feedback was positive, but the registered manager continued to identify areas for development for the service.

There was an action plan in place which included details of the actions the provider was going to take to ensure the service remained up to date with best practice in the field. The provider had approached an external agency to complete mock inspections to ensure they were up to date with expectations. The provider worked with other community organisations involved in people's care, and supported people to attend local community groups. The provider had ensured the service was sustainable by maintaining links with funding authorities and this had meant vacancies were filled when they arose. There were no plans to expand the service, and this reflected that the people who lived in the home preferred a small, homely environment.