Lifestyle Care Management Ltd

Ashmead Care Centre

Inspection report

201 Cortis Road
London
SW15 3AX

Tel: 02082466430
Website: www.lifestylecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an inspection of Ashmead Care Centre on 15 and 16 June 2017. The first day of the inspection was unannounced; the provider knew we would be returning for a second day. At our previous inspection on 30 June 2016 we found a breach of the regulation relating to consent. After our inspection, the provider wrote to us to confirm what they would do to meet the legal requirements in relation to this area.

Ashmead Care Centre is a care home with nursing for older people with dementia and/or nursing needs. There were 105 people using the service when we visited.

There was a registered manager at the service. 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.

At our previous inspection we found the provider was not meeting the requirements of the Mental Capacity Act 2005. We found one person was being unlawfully deprived of their liberty. At this inspection we found the provider was meeting this regulation. People's liberty was only being deprived in accordance with legal requirements for their safety and was the least restrictive option to achieve this aim. Where people's capacity was in question, we found mental capacity assessments were completed and decisions were made in their best interests after consultation with all relevant parties.

People were not consistently supported to meet their nutrition and hydration needs. Food and fluid charts were used, but these were not consistently filled in. People were otherwise supported to maintain a balanced, nutritious diet. Repositioning charts were not consistently filled in when needed. People were supported effectively with their health needs and were supported to access a range of healthcare professionals.

Procedures were in place to protect people from abuse. Staff understood how to recognise abuse and knew what to do if they suspected abuse was taking place.

Staff had completed medicines administration training within the last two years and were clear about their responsibilities. Medicines were administered, recorded and stored safely.

Staff demonstrated an understanding of people's life histories and current circumstances, and supported people to meet their individual needs in a caring way. We saw good levels of supportive interactions between care staff and people using the service.

People using the service and their relatives were involved in decisions about their care and how their needs were met. People had care plans in place that reflected their assessed needs.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. Staff were provided with appropriate training to help them carry out their duties. Staff received regular supervision. There were enough staff employed to meet people's needs.

People using the service and staff felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place.

The organisation had adequate systems in place to monitor the quality of the service.

During this inspection we found a breach of regulations in relation to nutrition. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. Repositioning charts were not consistently filled in. It was therefore, not possible to identify if people had been turned when needed. Procedures were in place to protect people from abuse. Staff understood how to recognise abuse and were aware of the provider's whistleblowing procedure.

The risks to people's mental and physical health were identified and appropriate action was taken to manage these.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

The service had adequate systems for recording, storing and administering medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective. People were not consistently supported to meet their nutrition and hydration needs. Food and fluid charts were in use where people required monitoring of their needs, but these were not consistently filled in. People were supported to maintain good health and were supported to access healthcare services and support when required.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments and Deprivation of Liberty authorisations were in place as required.

People were supported by staff who had the appropriate skills and knowledge to meet their needs. Staff received an induction and regular supervision and training to carry out their role.

Is the service caring?

Good

The service was caring. People using the service gave good feedback about the care workers.

We saw good levels of interaction between care workers and people using the service. People's privacy and dignity was respected and care staff provided examples of how they did this.

People were encouraged to develop their independent living skills and the service provided activities and resources to enable them to do this. People's cultural diversity was respected.

Is the service responsive?

Good

The service was responsive. People's needs were assessed before they began using the service and care was planned in response to these.

People were encouraged to be active and maintain their independence. Staff at the service encouraged people to take part in social events and arranged activities for them to participate in.

People told us they knew who to complain to and felt they would be listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. A number of audits were carried out by the registered manager and other senior managers within the organisation. However, these did not adequately address the gaps we identified in records relating to repositioning and food and fluid intake.

Feedback was obtained from people through residents meetings. People using the service and care staff gave positive feedback about the registered manager.

Ashmead Care Centre

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 took place on 15 and 16 June 2017. The first day of the inspection was unannounced; the provider knew we would be returning for a second day. The inspection team consisted of one inspector and a specialist advisor who was a nurse who specialised in dementia care.

Prior to the inspection we reviewed the information we held about the service. We spoke with one professional who worked with the service to obtain their feedback.

We spoke with 10 people using the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also spoke with eight care workers, four nurses, the activities coordinator, the chef, the registered manager and an area manager within the organisation.
We looked at a sample of 10 people's care records, nine staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. Comments included "I think this is a safe place" and "I feel safe."

Individual risks to people were assessed and records contained guidance for staff about how to manage these. For example, where people were at risk of pressure ulcers, risk assessments had been completed which identified the level of risk and a dedicated 'skin integrity care plan' contained detailed advice for care staff in how to manage this. The care plan included instructions about the use of pressure relieving equipment such as mattresses and cushions as well as the use of appropriate cream. Where people's needs required further monitoring, recording charts were in place. For example, people who required regular turning due to a risk of pressure sores had repositioning charts in place. However, we found these charts were not filled in contemporaneously and were usually filled in after a period of approximately four hours. We also saw previous repositioning charts were not fully completed and it was not clear whether people had been regularly turned or whether they had refused to be turned. Due to the inconsistency in completion of these records there was a risk that people were not turned as required to help prevent the development of pressure ulders.

We spoke with the registered manager about the frequency and accuracy of record keeping in relation to repositioning people. She confirmed that monthly care plan evaluations had been conducted in relation to people with skin integrity issues and these did not identify any concerns in relation to whether people were being turned when needed. She stated that staff had reported a difficulty in completing records contemporaneously. As a result, she confirmed that she was due to give notebooks to care staff to take contemporaneous records which they could transfer when they had time during the day.

We found risk assessments were in place to identify other specific risks to people and care plans were in place to effectively manage these. For example, we found 'moving and dexterity' assessments identified specifically what people's moving and handling needs were and whether they needed equipment to safely mobilise. Falls risk assessments were also conducted to identify whether people were at risk of falling and if so, measures were put in place to mitigate this risk. This included increased monitoring or the use of bed safety rails where needed.

Risk assessments were reviewed on a monthly basis or sooner if the person's needs changed.

The provider had a safeguarding adults policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated an understanding of how to recognise abuse. Care staff knew the procedure to follow if they suspected abuse was taking place. For example, one nurse told us "We cannot accept any kind of abuse. I would speak to the manager, the local authority and whistle blow if I needed to. We have all the numbers in our office."

The provider had a whistleblowing policy in place, and staff were aware of this. One care worker told us "I've never had to use this, but I would if I had to." Whistleblowing is when a care worker reports suspected

wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

Staff received emergency training as part of their mandatory training which involved what to do in the event of an accident, incident or medical emergency. Staff told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. For example, nurses and care workers told us the biggest risk to people's safety was falls. They explained the signs to look for in people which could indicate that they were at risk of falling and what action they would take to prevent falls. One care worker told us "We have one person in our unit who is at severe risk of falling so they have a one to one carer. Another [person] who uses [their] zimmer frame is also at risk of falling, so we all make sure we watch [him/her] closely to make sure [he/she] is ok." Care staff correctly explained what they would do if someone had suffered a fall or another medical emergency. There was an emergency call bell in place to alert all staff in case of an emergency and this could be heard by staff in the entire building. We saw call bells were in place in people's rooms and that these were within reach and in working order. This meant people could access help when needed.

We asked nurses about what they would do in the event of a medical emergency and they explained that they had undertaken emergency training to respond to these situations. Nurses were aware who was for and was not for resuscitation and people's care files had red stickers on the front to provide a visual indication of this. These details were also displayed on notice boards within the nurses' offices on each floor. This meant that staff could quickly identify whether or not to attempt resuscitation in an emergency situation.

People using the service and staff told us they felt there were enough of them on duty to do their jobs properly. People told us they felt their needs were responded to in a timely manner. Their comments included "Staff come when I ring the bell" and "I hardly use it, but they do come when I do". Care staff told us "I think we have enough staff on duty" and "There are enough of us on shift as you can see today. We don't use many agency staff either."

The registered manager explained that the number of staff members on duty at any time was originally negotiated as part of the initial contract with the referrer. This was reviewed according to the needs of all new people being admitted to the service. If more staff were required this could be renegotiated. If people with higher support needs were admitted, there were provisions in place to allocate an additional one to one care worker for them and we saw some people had this care in place. Senior staff at the service assessed people's needs on admission to determine whether they could be appropriately cared for. We reviewed the staffing rota for the week of our inspection and this accurately reflected the number of staff on duty. We observed care staff responding to people in a timely manner, responding to people's needs and they appeared to have adequate time to conduct their duties.

We looked at the recruitment records for nine staff members and saw they contained the necessary information and documentation to demonstrate that the provider had carried out checks to ensure that staff were suitable to work with people using the service. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms containing their employment history. Records of nurses also included their Nursing and Midwifery Council registration details.

Staff followed safe practices for administering and storing medicines. Medicines were delivered on a monthly basis for named individuals by the local pharmacy. Medicines were stored safely for each person in a locked cupboard and we saw the temperature was controlled, monitored and recorded on a daily basis. The temperature was at a safe level on the day of our inspection.

We saw examples of completed medicine administration record (MAR) charts for 15 people for the month of our inspection. We saw that staff had fully completed these. We checked the medicines available for six people and counted the amounts stored. We saw these tallied with the records kept.

Individual protocols were in place for "as required" (PRN) medicines. These included information to guide staff on when the medicine should be administered. PRN medicines for pain relief had specific protocols which included guidance for how to assess whether people were in pain and how to appropriately manage this.

We saw copies of monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. The checks we saw did not identify any issues.

Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines. We observed two nurses administering medicines to people and found medicines were administered safely and appropriately.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found one example of a person being deprived of their liberty for their safety, without the required authorisation in place. At this inspection we found that people's consent to their care and treatment was sought. Decision specific mental capacity assessments were in people's files to ensure that decisions were made in people's best interests where they did not have the capacity to consent to their care. Where people were deprived of their liberty for their safety, authorisations were in place from the local authority and the deprivation was the least restrictive option for securing this aim. 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 to 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).

Where monthly monitoring was required to ensure people's health needs were met, for example monthly weight checks, records showed that this was being done. We saw some examples of food and fluid charts being used for people who required close monitoring due to risks associated with their nutrition intake. However, not all of these were fully completed. Although we saw fluids were regularly offered and available throughout the day, we could not be fully assured that people's fluid and nutrition intake was adequately monitored as a result of these incomplete records. This may have put people at risk of their nutritional needs not being met as staff would not always have accurate information to hand about people's fluid and food intake and therefore would not know whether they needed to encourage further intake to meet their needs.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food available at the service. Comments included "The food is nice", "I'm a veggie and I'm well catered for" and "The food is lovely." We spoke with the chef about the food available. They explained that they obtained feedback about the food from the care workers who relayed people's views. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and we saw two different choices of food were offered for every meal. We sampled the lunch on the first day of our inspection. Food was appetising, of a good portion and served at the correct temperature.

People were encouraged to eat a healthy and balanced diet. People's care records included information about their dietary requirements which included details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. These included nutrition screening tools which were used to determine whether people were at risk of malnutrition. Based on this, people were monitored further or referred to specialists such as speech and language therapists or dietitians. There was evidence that the

provider acted upon the guidance received. For example, where people had been advised to have a soft diet, we saw specific instructions in place and observed people being given this.

We asked the chef how they provided food for people's varying health needs. They told us care staff relayed people's specific requirements and allergy information, but they also did not serve certain foods such as nuts due to the potential risk of these to people with an allergy.

People told us staff had the appropriate skills and knowledge to meet their needs. People said, "They're good" and "They know what they're doing." The registered manager told us, and care workers confirmed, that they completed training as part of their induction as well as ongoing training. Records confirmed that all staff had completed mandatory training in various topics as part of their induction. These topics included safeguarding adults, medicines administration and moving and handling people. There was also more specialist training available where required, for example specialist dementia training and nurses were expected to complete specific competency training modules in areas including pain management, medicines administration and pressure area care. We saw the home's training matrix and saw that people had completed training in the mandatory topics within the last two years.

Care workers confirmed they could request extra training where required and they felt that they received enough training to do their jobs well. One care worker told us, "We get lots of training. This is face to face and online."

Care staff told us they felt well supported and received regular supervision of their competence to carry out their work. We saw records to indicate that staff supervisions took place every two months. We were told by the registered manager and care workers that they used supervisions to discuss individual people's needs as well as their training and development needs. The registered manager told us annual appraisals would be conducted of care workers performance once they had worked at the service for one year and care workers confirmed this. We also saw records which demonstrated that these were taking place.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about peoples' health needs. When questioned, care workers demonstrated they understood people's health needs. For example, care workers were aware of people's specific health conditions and the symptoms associated with these. The service had close links with the local GP who visited the service every week.

Good

Is the service caring?

Our findings

People who used the service gave good feedback about the care they received. Comments included "The nurses treat me like a princess", "They're very kind and caring" and "The staff are nice."

Staff demonstrated a good understanding of people's life histories and demonstrated that they knew the people they were caring for. Care staff told us they asked questions about people's life histories and people important to them when they first moved into the service and we saw evidence of this information included in people's care records. Care records included a specific 'this is me' document which included details about where they had grown up, their family circumstances, people important to them and any previous occupation. Staff were able to tell us about people's lives and the circumstances which had led them to using the service. They were acquainted with people's habits and daily routines. For example, staff were able to tell us about people's likes and dislikes in relation to activities as well as things that could affect people's moods. For example one care worker told us one person "likes a cup of tea. It always makes [them] feel better" and another care worker told us one person "Doesn't like it when it gets too loud, so we make sure [the person] isn't around too much noise."

Care staff told us they respected people's choices and encouraged them to be as independent as possible. Their comments included "We give people choices about everything so they are in control of their lives" and another care worker told us "I never take over. I help them to do what they want."

We saw good levels of interaction between people using the service and care workers during our inspection. We observed the lunchtime period and saw staff respectfully assisting people with their meal and having conversations with them as they were doing so. We saw care staff having light-hearted conversations with people at other times in the day. Their behaviour indicated that they knew people well and were on good terms with them.

People told us their privacy was respected. One person said, "They respect me" and another said "They are polite." Care workers explained how they promoted people's privacy and dignity. Their comments included "[I] close curtains and door and keep [people] covered" and "People who don't need to be involved in care shouldn't be there. Explain what you are going to do and ask consent. Treat people with respect, it's very important." We observed staff speaking with people with respect and knocking on doors before entering their rooms.

Care records demonstrated that people's cultural and religious requirements and diversity were considered when people first started using the service. We saw initial assessments included details of people's cultural and religious requirements. The provider also had links with religious leaders from different faiths so care staff could support people to meet their spiritual needs. One person did not speak English as their first language and we observed staff speaking with them using phrases they had learnt in their native language.

Good

Is the service responsive?

Our findings

People told us they were involved in making decisions about their care. One person told us, "They do what I ask them and I don't have to repeat myself."

People were encouraged to express their views and be involved in decisions regarding their care. People were given information when first joining the service in the form of a 'service user guide' which included details of the service provided and the core values of the service. Residents meetings and additional relatives meetings were held every three months. We saw minutes relating to these meetings and saw various topics were discussed and actions had been taken to rectify issues raised. Care records also included people's views and staff explained that they prioritised people's choices in relation to their care. They told us people's food preferences, their preferred routines and their preferred activities.

People's needs were assessed before they began using the service and care was planned in response to these. Assessments were completed in various aspects of people's medical, physical and social needs. The care records we looked at included care plans in areas including nutrition, continence and moving and handling which had been developed from the assessment of people's individual needs. Care records showed staff considered people's views in the assessment of their needs and planning of their care. Care plans included details about people's preferred routines, habits, likes and dislikes in relation to a number of different areas including nutrition and activities. Care records we saw were updated in accordance with people's changing health needs.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. We saw from people's care records that people's likes and dislikes in relation to activities were recorded and we received good feedback about the activities on offer. Comments included "I enjoy all the activities" and "I get involved if I'm in the mood."

The service had six activities coordinators and we spoke with one on the second day of our inspection. They were aware of people's feedback and had made notes of people's preferences in relation to activities. They told us they would use this feedback to make changes to next month's activities programme. They told us "People prefer ball games and balloon games, so we do a lot of these." There was a monthly plan of activities which was displayed on a notice board for residents which included one morning activity and one afternoon activity. Types of activities on offer included cake decorating, watching movies and playing games with a ball or parachute and skittles.

We asked the activities coordinator how they engaged people who could not leave their bed. They told us "There is something I can do for everyone, but some people don't want to take part in any activities. I make sure I visit them as often as possible even if it's just for a chat."

The service had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We saw records of complaints and saw these were dealt with in line with the provider's policy. We saw the

complaints policy was displayed on notice boards within the building so people were aware of this. Monthly 'resident's meetings' also took place so people could discuss any complaints or issues they had in a formalised setting.

Care workers we spoke with confirmed that they discussed people's care needs on a daily basis at any time, but also within daily handover meetings and in their supervision sessions and team meetings. They told us if there were any issues or complaints they would discuss them with senior staff immediately and at any of these times.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems to monitor the quality of the care and support people received. We saw evidence of numerous audits covering a range of issues such as people's weight, pressure sores, medicines, falls management and infection control. These included an action plan. However, not all areas of care were adequately monitored to ensure that people's needs were met at all times. For example, we found that turning and repositioning records and food and fluid charts were not always fully completed and therefore people may have been at risk of not receiving care and support as required.

The service had an open culture that encouraged people's involvement in decisions that affected them. People and care staff gave positive feedback about the registered manager. Care staff told us "She's terrific", "She's excellent. She always does the right thing for us" and "She tells you what you need to do, but in a nice way. You don't want to let her down."

The registered manager told us staff meetings were held every two months to discuss the running of the service. Staff told us they felt able to contribute to these meetings and found the topics discussed were useful to their role. We read the minutes from the most recent staff meeting. These showed that numerous discussions were held with actions and identified timeframes for completion.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with detailed explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was received during 'residents' meetings and separate relatives meetings. The registered manager told us that if issues were identified they would be dealt with individually.

We saw records of complaints, and accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor trends or identify further action required and we saw evidence of this. They told us all accidents and incidents were also reviewed by senior staff at the provider's head office. Staff at the head office monitored incidents for trends and made further recommendations where required.

Information was reported to the Care Quality Commission (CQC) as required. We spoke with a member of the local authority and they did not have any concerns about the service.

The provider worked with other health and social care professionals to ensure the service followed best practice. We saw evidence in care records that showed close working with local multi-disciplinary teams, which included the Behaviour and Communication Support Services, the GP and local social services teams. We spoke with one health and social care professional and they commented positively on their working

relationship with staff at Ashmead Care Centre.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not mitigate the risks of service users nutritional and hydration needs not being met. 14(1).