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Ashleigh Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 December 2016 and was unannounced.

Ashleigh Nursing Home is registered to provide nursing and residential care up to 21 older people, with some of the people living with dementia. At the time of our inspection there were 17 people using the service. The service is located within a residential area and provides accommodation over two floors.

The previous comprehensive inspection of 15 December 2014 found the service to be compliant with the regulations. Areas of improvement were identified.

Ashleigh Nursing Home 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.

We found improvements were needed to ensure people's rights were upheld and that the provider, registered manager and staff acted in accordance with the Mental Capacity Act 2005 (MCA). We found conditions which authorised the restriction of people's rights were not being met. We also found a lack of awareness as to the appropriate and correct completion of mental capacity assessments. The registered manager said improvements would be made in this area.

People's safety and well-being was promoted through the management of risk. This was achieved through the sharing of information with all those involved in the person's care, which included health care professionals. Where necessary equipment was used to enable people to move around the home safely.

People's safety was further supported through a robust recruitment process for staff and by their being sufficient staff to provide the support people required. Staff undertook training and they were regularly supervised, which included having their competency assessed to ensure they delivered safe and effective care and support to people.

People were encouraged to make decisions about their day to day lives. People's care plans provided information for staff as to what support people required, so that people's independence was recognised and not undermined by staff. We observed staff supporting people to make decisions about their day to day lives and provided encouragement in the promotion of their independence.

People's health and welfare was promoted through a range of assessments and the development of care plans which were regularly reviewed. People, with the support of staff where required, accessed the services of a range of health care professionals who monitored and promoted their health. People's nutritional needs were assessed and met and regularly reviewed. People's medicines were managed safely and effectively.

Staff had time to spend with people engaging them in conversation. When providing personal care and support staff promoted people's privacy and dignity. Staff were seen to respond to people's changing needs, which included supporting people sensitivity and kindness when they became upset or distressed. All interactions by staff were recorded onto hand held electronic devices. This meant all staff had access to up to date information as to the health and welfare of each person throughout the day so they could respond to people's needs.

The provider had systems in place to monitor the quality of care being provided, which included seeking the views of people using the service and their family members. The provider was working with external organisations to bring about further improvements to the service being provided. They had purchased a computer software package to assist in the assessing and recording of people's needs to support the delivery of high quality care.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for Ashleigh Nursing Home is requires improvement as a breach in the regulations was found.

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?

Good

The service was safe.

Staff were aware of their responsibilities in alerting the provider or registered manager to concerns, however not all staff were aware of external agencies they could contact.

Risk assessments were in place and followed to minimise risk to people to promote their safely.

People were supported and cared for by sufficient numbers of staff to ensure their individual needs were met.

Systems were in place for the management of people's medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not fully understood or implemented, having the potential to compromise people's rights.

People received support and care from a staff team who were knowledgeable about their needs.

People's dietary needs were met.

Staff were proactive in supporting people to maintain their health as people had access to a range of health care professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring and who spent time with them providing reassurance, care and support.

Staff encouraged people to make decisions about their day to

day lives and about the care and support they received.

Staff respected people's privacy and dignity and independence, which was acknowledged by the relatives of people using the service in their written comments.

Is the service responsive?

Good

The service was responsive.

Care plans detailed the care and support people required and were regularly reviewed. The environment had considered the needs of people living with dementia, through its decoration and areas of interests being provided.

People told us that the registered manager and staff team were approachable should they have any concerns.

Is the service well-led?

Good

The service was well-led.

The provider and registered manager did not consistently meet their legal obligation to inform the CQC about specific events within the service.

The provider and registered manager were visible in the day to day running of the service and were approachable to those using the service, their relatives and staff.

The provider and registered manager were committed to the continued further development of the service to ensure good quality care was provided.

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 29 December 2016 and was unannounced.

The inspection was carried out by an inspector and a specialist advisor. The specialist advisor had experience of working and supporting older people living with dementia.

We gathered and reviewed information about the service before the inspection. This included the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications we had received from the provider. Notifications are information about key incidents and events within the service that the provider is required by law to tell us about. We also contacted local health commissioners who fund many of the people using the service to gather their views of the care and service.

We used a variety of methods to inspect the service. Some people's needs meant that they were unable to verbally tell us how they found living at the service. Two people were able to provide us with limited responses about how staff supported them. We spent time with people which included observing them being supported in communal areas and at meal-times. We also spoke with the provider, the registered manager, two nurses, a senior carer and a carer.

We looked at the records of three people, which included their plans of care, risk assessments and medicine records. We also looked at the recruitment of three members of staff, quality assurance audits and the minutes of meetings. The registered manager provided us with a matrix detailing staff training following the inspection as requested.

Good

Is the service safe?

Our findings

Staff told us how they supported people in staying safe. "We make sure the environment is free from obstacles, to prevent people from falling." A CCTV camera for the external environment was in operation, which meant staff could see people arriving at the front door before opening it, helping to promote people's safety. 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, further promoting people's safety.

Staff were clear about their role and responsibility in reporting their concerns. We asked staff how they would identify whether someone may be experiencing abuse or avoidable harm. Staff told us that in addition to physical signs such as bruising they would note changes to people's behaviour, such as becoming withdrawn and quiet. This meant people using the service could be confident that the welfare and safety of people was understood by staff and that staff would take the appropriate action. Staff told us they would report any concerns to a member of the management team. However not all staff were aware of external agencies they could contact such as the CQC or local authority. We spoke with the registered manager, who told us they would ensure all staff were aware of external agencies and their contact details by raising staff awareness in a staff meeting.

Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, all new staff had an enhanced Disclosure and Barring Service (DBS) check, two references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may affect their working with people, which may impact on the safety of those using the service.). The records of nursing staff showed that the provider made checks to ensure nursing staff were registered with the appropriate professional body, which meant they were registered to provide nursing care safely. This confirms information as detailed within the PIR.

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. 'Training on moving and handling, means I know how to move people safely using equipment."

There were systems in place to reduce risks to people using the service. Assessments of any potential risks had been carried out and guidelines put in place so that any risks could be minimised, whilst recognising the rights of people to make decisions about their day to day lives. For example risk assessments were carried out to identify whether people were at risk of falling. Staff we spoke with evidenced a good awareness of people's risk assessments and care plans. Our observations showed staff followed these, which meant people's safety and welfare was promoted.

Assessments of risk were carried out on people who had individual medical conditions, such as dementia, heart disease, mental health and diabetes. The assessment assisted nursing staff to identify those people who may require higher levels of care, support and monitoring. The outcome of the assessment provided an indication as to how often nursing staff should review a person's care plan. For example monthly, weekly or daily and prompted staff to liaise with relevant health care professionals. This approach to potential risks

helped nursing staff to respond to people's changing needs and to take the appropriate action to maintain their safety and welfare.

Our observations showed there were sufficient staff on duty to provide care and support for those living at Ashleigh Nursing Home and that staffing numbers were flexible to meet people's needs. Staff were visible to people using the service and were able to provide timely support and care. The registered manager told us staffing levels were reviewed dependent upon the number of people in residence and their needs. A software computer package recorded the information gathered from assessments of people's needs, which provided the provider and registered manager as to the resources (number of staffing hours) required to provide a person's care safely and effectively.

People's medicine was kept safe within a lockable facility along with their medicine administration records. We found people's routine medicine and all records reflected the safe management of their medicine. We found medicine administration records had been signed by staff when they had administered people's medicine and records accurately reflected the quantity of medicine on site. Records were in place where medicine was returned to the supplying pharmacist. We found the medication policy had been revised with the support of a pharmacist as stated within the PIR. People's medicine had been reviewed and people's records updated to reflect any changes.

We spoke with a 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 they knew someone was anxious by noting changes to the person's behaviour.

Requires Improvement

Is the service effective?

Our findings

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 application procedures for this in nursing and care homes 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. We found ten people had a DoLS authorisation in place. We found the conditions on one person's authorisation were not being fully met, which meant the person's rights were not being upheld. We discussed this with the registered manager and the nurse as to the changes they would introduce to ensure the person's rights were upheld and that staff worked in accordance with the conditions of the DoLS. They assured us that all care interventions would be recorded, and the person's care plans reviewed to provide clear guidance for staff. This would include guidance as to when medicine was administered as and when needed, and as prescribed, to support the person's health and well-being.

We found a person's capacity to make informed decisions about key aspects of their day to day care and support had been considered. However we found the capacity assessment had not been completed consistent with MCA guidance. The person's capacity to make decisions about different aspects of their care, nutrition, medication and personal care had been recorded on one document. The information about the three areas of care was not specific and therefore it was unclear as to what decisions the person was able to make within these areas. Another person's records at the time of their admission said '[person's name] does not have the mental capacity to take even basic decisions.' There was no evidence of any MCA documentation to support this statement. We spoke with the registered manager and nurse who told us that all capacity assessments would be reviewed to reflect the MCA.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their role in ensuring people consented to their care and support, and its importance to the person. Staff told us, "We provide choices to people, such as asking them what they want to wear. We need to make sure that people are encouraged to make decisions to the best of their ability." And, "It's important that we read people's care plans so we know they indicate choice so that we can understand and respect their choices."

Staff were seen encouraging people to make decisions about their day to day lives, for example by asking

people if they wanted a drink and asking people if they wished to eat their lunchtime meal in the dining room. We saw people's views were respected, with some people being supported to go to the dining room, whilst others who had chosen to remain in a lounge, had a table positioned by their chair so they could eat.

In some instances people had made an advanced decision about their care with regards to emergency treatment and resuscitation, which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This had been put into place with the involvement of the person, their relative or representative and health care professionals. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

Staff told us about their induction; a staff member told us "I worked alongside a member of staff, and read people's care plans and key policies and procedures." And, "I worked alongside other nurses, read care plans and observed medicine administration." They told us this had enabled them to become familiar with the service and the care people required, and their role in the provision of care.

Newly appointed staff completed an induction period upon their initial appointment. Staff were also required to read the services policies and procedures and people's care plans. Some newly appointed staff were working towards attaining The Care Certificate, which is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. This confirmed the information recorded within the provider information return.

A member of staff told us how they were undertaking a training course in management and leadership as part of their development. This showed the registered manager was effective in the development of staff with a view to promoting quality care for people.

The training matrix we looked at reflected that staff had received training in a number of topics. The registered manager provided informed us of the training that had been scheduled, which included further training on the Mental Capacity Act. The provider had within the PIR identified an area for planned improvement was the delivering of training for staff in the care of people with dementia.

The provider and registered manager provided formal supervisions, through one to one meetings; this provided an opportunity for staff to talk about their role within the service, their training as well as providing an opportunity to share their thoughts and concerns. In addition staff had their work 'observed' by the provider and registered manager, to which feedback was provided. The purpose of observed supervision was to ensure that staff delivered people's care consistent with their care plan, so that the provider could ensure themselves that people were receiving effective care. This confirmed the information recorded within the PIR.

We sat with staff during the 'handover', where information from staff on duty in the morning was shared with staff arriving on duty in the afternoon. Staff referred to their electronic hand held devices which were used by staff to record people's health care and the support and car provided. Information about people was shared, which included any follow up action required. An example, being when a person had declined their lunchtime meal, it was agreed for staff to offer the person something to eat later in the day. The discussion reflected on the person's favourite foods and who from the staff team would be best suited to encourage the person to eat. We observed later the person accepting something to eat, which showed how effective communication between staff, meant people's health and welfare was promoted.

We wanted to find out about the dining experience for people, so we spent time in the dining room at lunchtime with five people. Where people required support, including encouragement to eat their meal this

was provided by staff in a sensitive manner. People had the choice of two meal options. We saw that people were regularly offered snacks and drinks throughout the day and where people requested a drink, this was provided by staff. This showed that staff ensure people had sufficient to eat and drink to promote their health and welfare.

We found the provider had taken active steps to encourage and support people living with dementia to eat their meal. People living with dementia can experience difficulty with sight and perception, which means they may find it difficult to recognise food served on a white plate. We found people's food had been served on colourful plates, to help them to see and distinguish between the different foods on the plate.

The PIR reflected staff from the service had close and strong support from health professionals when needed, which included visiting practitioners who had experience in specific fields, which included tissue viability, pressure care and catheter care. Further support to maintain and promote people's health was provided through visits to Ashleigh Nursing Home by dentists, chiropodists, and opticians. People's records showed that health care advice was followed by staff and people's care plans were updated to reflect any changes to ensure people's health needs were met.

Good

Is the service caring?

Our findings

We spoke with people about the support and care they received, they told us. "The staff are jolly, which helps me to stay positive." "The girls (staff) are very friendly and always smiling."

The views of people's relatives had been sought by the provider, and their comments were reflective of a caring approach by staff, 'I have been impressed by the dedication and attitude of staff. The calm and relaxed atmosphere they create.' 'Ashleigh Nursing Home has a lovely atmosphere; we are really impressed and pleased and feel [person's name] is in safe hands.'

People were seen to take pleasure in staff spending time with them. One person was seen talking about a book with a member of staff, whilst we saw other people holding conversations with staff about things that were important to them.

When people became distressed or anxious we saw staff spend time with them, providing reassurance, which helped them to relax. For example, one person's behaviour became challenging at lunch time, when they were asked if they wished to go to the dining room to eat. Staff were seen using different approaches to the person's care in encouraging them to eat their lunch.

We found positive relationships had developed between the relatives of people using the service and staff. During our inspection a recently bereaved relative spoke with the registered manager on the telephone and was heard to be complimentary about the care of their relative and staff whilst they had been at Ashleigh Nursing Home.

People's care records provided information about their lives, about their family, work life, hobbies and interests. The information was used by staff to provide people's support For example, in talking about topics of interest to people. Information was also used to support people in other ways. For example, one person's records stated that talking with the person about their work life helped to reduce their anxiety; whilst the records of another person detailed the type of music they enjoyed listening to when they became distressed.

Additional comments made within the questionnaires, along with comments received within thank you cards reflected relative's satisfaction with the care provided and of the friendly and homely atmosphere of the service. People's written comments made specific reference to peoples care during their final days, prior to their death and included; 'The support in particular during the last days and hours of mum's life, saw her leave this life with dignity, respect and peacefully.'

Good

Is the service responsive?

Our findings

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 the persons care plan. We also found that information provided by the person's relative was being shared with staff to enable them to provide support and comfort to support the person in settling into their new environment.

The provider within the PIR referred to the introduction of a 'person centred care' computer software package. The registered manager showed us how information from people's paper records was being transferred onto the computer system. The software package was being used by the registered manager and nursing staff to update and record the care and support people received, which included producing care plans. Staff had hand held electronic devices, which meant all interactions with people, which included all aspects of care, were recorded at the time the care was provided. The system also alerted staff when aspects of people's care and support needed to be provided, for example, where the person due to their health remained in bed, it reminded staff to re-position the person to promote good skin integrity and to reduce the risk of the development of pressure areas. This meant staff had access to up to date information which enabled them to provide care and support to meet individual needs.

Staff showed us how the hand held electronic devices were used by them. For example a person who was experiencing some pain requested medicine. The nurse on duty administered the medicine and then updated the electronic record, which meant all staff when looking at the person's records knew they had requested and had been administered medicine to manage their pain. The software required staff to detail the type of interaction or care provided and the impact this had had on the person. This was done by staff selecting icons which helped to illustrate this, for example a symbol of a visitor and a smiley face to indicate the person had received a visit from someone, such as a relative and friend, and this had been something the person had enjoyed.

The environment had some adjustments made to meet the needs of people living with dementia, for example by using décor, signs and symbols to assist people in locating facilities within the home, such as clear pictorial signage on toilet and bathroom doors. The environment had been used to provide points of interest for example, communal areas of the service had been decorated with 'themes' in mind. This included a corridor displaying three dimensional sports equipment, which included a football, tennis ball and racket.

The rear garden area had seating, which overlooked a wall which had been painted to represent places of interest for people to look at, which included 'shop fronts', a butchers, green grocers and post office to name some. The provider informed us of plans to further develop the environment, which would be to create a 'cinema' style room in one of the lounges. Adaptations to the environment are recognised to support people living with dementia.

Two staff were attending on-going training to provide guidance and information on supporting people living with dementia. Staff told us the training was interactive and based on 'themes', which had included the

seaside and childhood memories and school days. Prompts were used to stimulate conversation and interaction with people. The prompts had included a 'Punch and Judy' show, which the staff had performed. We asked staff how people using the service had reacted to the prompts from the themes. A staff member told us one person, who had travelled in their earlier years, had responded by talking about their childhood family holidays and the places they had visited and their experiences of living overseas in their earlier years. Staff told us people spoke of the postcards and eating fish and chips. The childhood school day's theme had included school satchels and uniform, photographs, skipping ropes and sweets of the time. Staff told us this had again prompted discussion, with one person particularly enjoying the sweets.

We found people were aware of how to raise concerns; however those we spoke with said they had no concerns or complaints about the home. They told us, "I'm content here." "I have nothing I wish to complain about." And, "All good here." The registered manager informed us they had not received any concerns or complaints within the last 12 months, this reflected the information within the PIR.

Good

Is the service well-led?

Our findings

We found that the provider, registered manager and staff promoted a positive and friendly culture which provided opportunities for people to comment upon and influence the service they receive. People and their relatives' views were sought through an annual questionnaire. The information gathered from questionnaires was analysed and shared through a newsletter, copies of which were available from the service. The most recent annual report showed a good level of satisfaction with all aspects of the service, which included the attitude and approach of staff and the quality of the care provided. The findings had been analysed and shared, along with other information, in a newsletter.

We asked staff what communications systems were in place to enable them to work well. We were told that individual supervisions (one to one meetings) took place, where staff had the opportunity to discuss the needs of people using the service, their personal training and development and suggestions as to the development of the service. Staff also told us daily 'handovers' of information between members of the staff team promoted consistency of support to people by ensuring all staff were informed about people's health and welfare and events within the home.

The provider and registered manager were approachable to those using the service, their relatives and staff. The provider regularly visited the service and was seen to have a good rapport with those using the service and the staff they employed. We spoke with the provider and registered manager to find out how they assured themselves of the quality of the service they provided. They shared with us the audits they had undertaken, which reflected a range of topics, which included health and safety within the home and medicines records. The audits found systems in the service were working well and where improvements were needed.

We found staff meetings had taken place, which we used to share information, and provided an opportunity for the provider and registered manager to speak with staff about any changes to the service, which included the outcome of audits undertaken. Minutes of meetings showed specific areas for improvement had been identified, which included development of care plans by nursing staff and the encouragement of people in the signing of these. This showed action was taken where shortfalls had been identified to ensure improvements were made to the quality of care people receive.

The provider and registered manager have a legal responsibility to inform the CQC of specific incidents or events within the service, these are known as notifications. The PIR recorded that a number of people had a DoLS authorisation in place, which we confirmed during our inspection. We found we had not received notifications about people who had an authorised DoLS in place. We spoke with the provider about this who assured us improvements would be made any notifications submitted. The provider and registered manager had upheld their legal responsibility in relation to other incidents or events as we had received notifications, which included where people had died.

The registered manager at the previous inspection told us they were speaking with the provider about increasing the number of days they spent focusing on the day to day running and management of the

service instead of directly providing nursing care to people. The registered manager told us the number of days providing direct nursing had decreased and that three days were now dedicated to the day to day management of the service.

Whilst information we requested was available, we found there was no definite plan of where information might be held, which meant it took time to gain access to the information we needed. The introduction of the computer software package for recording people's care needs should, once fully implemented improve the organisation and accessibility of people's records, which will assist all those involved in people's care in accessing information in a timely manner.

The local Clinical Commissioning Group and Commissioners from the local authority fund the care of people who use the service. Representatives from these organisations had undertaken quality audits in 2016 of the service being provided; and had identified improvements were needed in some areas. Action plans had been developed by these agencies and the provider and registered manager confirmed they were working to bring about improvements. We contacted representatives of these organisations who told us they continued to monitor the service through visits and had found improvements were being made. They told us the provider and registered manager were keen to bring about improvement.

The provider shared with us planned improvements, which included the redecoration of some areas of the home, purchasing of new comfy seating for the communal lounges, and changes to one of the lounges to reflect a 'cinema' style room, so people could sit and watch films. The PIR in addition had recorded planned areas of improvement within the next 12 months. These reflected the need to improve the lives of people living with dementia by further developing the environment to meet their needs and through staff training. Other areas for development included encouraging and supporting people and their relatives, through meetings, to share their views about the service.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not acted in accordance with the Mental Capacity Act 2005 and had not implemented the conditions of a person's authorised Deprivation of Liberty Safeguard (DoLS).