# Inspection Report

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

# Ashdown Lodge

2 Wendy Ridge, Rustington, Littlehampton, BN16 3PJ

Tel: 01903785251

Date of Inspection: 14 October 2013

Date of Publication: November 2013

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

| | |
|---|---|
| **Consent to care and treatment** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Management of medicines** | ✓ Met this standard |
| **Staffing** | ✓ Met this standard |
| **Complaints** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Mrs Janet Tucker |
| Registered Manager | Mrs. Bridget Hart |
| Overview of the service | Ashdown Lodge provides support and accommodation for up to thirteen older people with a variety of long term conditions and disabilities. It is situated in a residential area of Rustington, West Sussex. At the time of inspection, there were twelve people living at the home. |
| Type of service | Care home service without nursing |
| Regulated activity | Accommodation for persons who require nursing or personal care |

# Contents

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

## Summary of this inspection

### Why we carried out this inspection

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

This was an unannounced inspection.

### How we carried out this inspection

We carried out a visit on 14 October 2013, observed how people were being cared for, talked with people who use the service and talked with carers and / or family members. We talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

### What people told us and what we found

We spoke with three people who lived at the home. They were satisfied the care and support they received and were happy living at Ashdown Lodge. One person told us, "It's excellent. I have no complaints at all". Another said, "I struggled when I came here but the staff made it easy to settle in". A relative said,"It's a small home so it feels much more personal than the bigger ones". We noted that the home provided a wide range of social events and activities organised by the deputy manager; the people we spoke with were happy with the number and variety of activities on offer.

We saw that consent was sought from people before giving care and support whenever practicable. We observed that the care given was safe and appropriate and based on effective care planning and risk assessments. This meant that people's individual needs were met and preferences were taken into account.

People were protected from the risks associated with poor medication management. We saw that medicines were properly handled and administered in line with the providers policy. We noted that there were adequate numbers of staff to provide safe care. We also found that systems were in place for people and relatives to make a complaint about the service if necessary.

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

## More information about the provider

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

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

## Our judgements for each standard inspected

**Consent to care and treatment** ✓ Met this standard

**Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

### Reasons for our judgement

We spoke with three people who used the service, two relatives, examined five care plans and daily records and observed interactions between people and staff. We spoke with two staff members. We also examined the provider's policy and documentation in relation to consent to care and treatment. The people we spoke with told us that staff always asked before offering care or support. Our observations confirmed this. We heard staff using phrases such as, "Would you like to?.." and "Can I help you with that?...". One person said, "If I have a good day and can do things for myself I do, but they will help me when I need it". Another told us, "I need a lot of help these days but they don't just presume and take over". We noted that the provider had devised a Quality Care and Service Charter which outlined people's rights to make choices for themselves whenever possible. We were told that staff's achievements in this area were formally recognised by the provider.

The care plans and daily records we looked at provided evidence that consent had been sought before treatment was given or care and support offered. For example, we noted that the provider made efforts to allow people to manage their own medication where possible if they wished. We saw that mental capacity assessments were undertaken as part of the process and that people would be asked to sign a consent form before self-medicating. We also found evidence from the care plans and our observations that options for care and treatment were explained in a way people could understand. On our visit to the home, we noted that no-one was subject to Deprivation of Liberty Safeguards (DoLS).

The staff we spoke with had a clear understanding of the implications of the Mental Capacity Act 2005 in areas such as the general principles of consent and acting in people's best interests. We found evidence that staff had undertaken relevant training in this area. This meant that staff were able to provide care consistent with the law. One staff member said, "We always ask before helping as it's the right thing to do. Also, people's desire and ability to give consent can change daily. We can never presume anything".

**Care and welfare of people who use services** ✓ Met this standard

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

## Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

## Reasons for our judgement

The people we spoke with at the home clearly held it in high regard and praised both the quality of care and the way in which it was delivered. One person told us, "I must say I moved here with some trepidation but it's been marvellous. I could barely walk when I came here but I'm much better now".

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Some of the people living at the home had complex needs and were unable to verbally communicate their views and experiences to us. To address this issue, we used a formal, research-based method to observe people in order to understand how their needs were met. This is called the 'Short Observational Framework for Inspection' (SOFI). We undertook observation of care using the SOFI tool at lunchtime and found the care to be safe and appropriate, with adequate number of staff present. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. However, we noted that the majority of people present during the observation were unable to express their needs. They received the right level of support, for example in assisting people with their meals where necessary. It was evident through our observations that staff had enough skill and experience to achieve this and meant that the care given was of a consistently high standard.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The care plans and daily records we examined were well-ordered, concise and legible. We found evidence of care planning and individual risk assessment having been undertaken, which was reviewed monthly and updated in line with people's changing circumstances. We noted that staff members had undertaken recent and relevant training in this area. The risk assessments were clearly focused on the individual in areas such as managing the risks associated with the use of hot water bottles and the management of people's skin integrity . There was also evidence of good communication in the management of people's care between the home and other agencies such as the community physiotherapist and the local NHS Trust's Dermatology Nurse Specialist. We noted that advice and guidance given by these professionals was followed

up by the home and properly documented. This meant that the care given was relevant, up to date and person-centred.

The staff we spoke with were knowledgeable about people's individual needs and preferences. We noted, by observing care, that staff were focused on promoting people's independence and self-esteem at every opportunity. A staff member told us, "It's a small home so we know them really well". We noted that the home provided a wide range of social activities in both groups settings and on a one-to-one basis.

There were arrangements in place to deal with foreseeable emergencies. We observed that the home had clear protocols to follow in case of emergencies, such as an outbreak of fire or a person choking on their food. All staff received regular fire risk assessment training and training in the care of substances harmful to health. The staff we spoke with were clear about their responsibilities in this area.

**Management of medicines** ✓ Met this standard

**People should be given the medicines they need when they need them, and in a safe way**

## Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

## Reasons for our judgement

Appropriate arrangements were in place in relation to the obtaining and disposing of medicine. We noted that adequate supplies of medication had been maintained so that people could receive them when needed. These were delivered by a local pharmacist on a 28 day cycle via a monitored dosage system. We saw that unused medication was disposed of by the pharmacist on a regular basis. This was documented in the provider's 'Returns to Pharmacy' book. There were clear and concise policies accessible to staff in relation to these issues.

Appropriate arrangements were also in place in relation to the recording of medicine. We examined the Medication Administration Records (MAR) for six people living at the home. We noted that staff recorded the administration of medication in line with the provider's policy. There were no gaps in the records. We examined the controlled drugs book and found no discrepancies. The recording of drug administration was also subject to regular internal and external audit.

Medicines were safely administered. We found evidence that only trained, authorised staff were involved in medicine administration. We saw that staff undertook relevant training and were regularly assessed by the home manager. This meant that people were protected from the risks associated with inappropriate medication management. We saw that the home followed clear guidelines around the administration of 'only when needed' medication. There were also appropriate protocols in place in the event of drug administration errors.

Medicines were kept safely. We observed that medication was stored in a lockable cabinet to which only authorised staff had access. Controlled drugs were kept in a separate, locked container. Mental capacity assessments had been undertaken and no-one at the home administered their own medication at the time of inspection.

**Staffing** ✓ Met this standard

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

## Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

## Reasons for our judgement

We spoke with people living at the home, relatives and staff members. We also examined the duty rota covering a recent four week period and looked at the provider's documentation pertaining to staff training. The people we spoke with were satisfied that there were adequate numbers of staff to care for people safely. One person told us, "They are very busy but I never have to wait". We noted from our examination of the duty rota that staffing levels adequately reflected the number and circumstances of people living at the home. We saw that the provider took action to ensure this by operating an internal bank system comprised of existing staff in order to cover vacant shifts. This meant that the home was able to raise staffing levels when needed to maintain safe and appropriate care. One relative told us, "I visit whenever I want and my relative always looks well cared for".

We noted, through our examination of documents related to training and talking with staff, that they received regular updates in areas relevant to the care needs of the people they were looking after. These were in areas such as maintaining people's dignity and respect and safeguarding vulnerable adults. The staff we spoke with were happy with the type and frequency of training on offer. A staff member told us, "There is training on offer here and it helps us deliver better care". This demonstrated that staff were able to provide safe, up to date care in line with current research and legislation.

**Complaints** ✓ Met this standard

**People should have their complaints listened to and acted on properly**

## Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

## Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs, either in written form to them or their relatives on admission to the home, or informally via staff members subsequently. The people we spoke with felt that they could make a complaint if they needed to and would be listened to. One person told us, "I could tell any of them (staff) really. They would all listen". A relative said, "I see the manager regularly anyway. It would just be a matter of popping my head round the door and discussing it. I'm sure we would work it out". We examined the complaints policy and found that it included clear guidelines on how and by when issues should be resolved. The relatives we spoke with understood that complaints not resolved locally could be referred to an external agency, such as the Local Authority Ombudsman.

We were told that there had been no complaints this year. We found evidence that the home manager regularly discussed matters relating to care with people and their families on a one-to-one basis and acted in accordance with findings. Our observations indicated that the provider operated an 'open door' policy in which people, their relatives and staff could raise issues important to them.This meant that people had their comments listened to and acted on, without the fear that they would be discriminated against.

## About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

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

## How we define our judgements

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

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

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

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

## Glossary of terms we use in this report

### Essential standard

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

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

### Regulated activity

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

## Glossary of terms we use in this report (continued)

**(Registered) Provider**

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

**Regulations**

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

**Responsive inspection**

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

**Routine inspection**

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

**Themed inspection**

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

## Contact us

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|---|---|
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