Care First (Smethwick) Ltd

Ash Lodge Care Home with Nursing

Inspection report

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West Midlands
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection visit which took place on 21 September 2017.

Ash Lodge Care Home provides nursing and personal care to a maximum of 54 adults. The service consists of two separate units over two floors; the nursing unit on the ground floor and the dementia care unit on the first floor. On the day of our inspection there were 53 people at the home.

At the last inspection in November 2014 the service was rated Good. At this inspection we found the service remained Good.

There was a registered manager; however she was not present on the day of the inspection. 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.

People who lived at the home were kept safe because staff were trained to identify signs of abuse and understood reporting procedures. Potential risks of harm to people had been identified and guidance for staff was in place to support people safely. There were enough staff to support people and staff had been recruited safely. People received their medicines as they were prescribed.

People were supported by staff who had the training and skills to consistently meet people's changing needs. Staff had regular supervision and support to reflect on and develop their care practices so that people benefitted from quality care. Staff understood the importance of seeking people's consent before care was delivered. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People told us they were happy with the choice and quality of the meals provided and staff understood the need to support people who were poorly or living with dementia to eat and drink sufficient amounts to maintain their health. People were supported to access health care professionals without delay to maintain their health.

People described the staff as very caring, attentive, polite and patient. People enjoyed the fact that staff spent time with them. People's privacy and dignity was protected by staff and people were encouraged to maintain their independence. The development of care practices to support people approaching the end of their life showed a compassionate response to people's needs.

People were supported by a dedicated activities team who provided a variety of regular events for people to enjoy. People and their relatives told us they were confident that if they had any concerns or complaints they would be listened to and that the registered manager would strive to resolve these.

Staff spoke positively about the management of the home and felt supported by the management team. There were several different platforms used in which people could voice their opinions on the service and we saw the management team used feedback and comments to continually improve the service. Everyone including external professionals told us the home was welcoming, had a nice atmosphere and was well organised. The registered manager and provider had continued to monitor the quality of the service and had further developed aspects of the service to provide better outcomes for people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Ash Lodge Care Home with Nursing

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 21 September 2017 and was unannounced. The inspection team comprised of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was caring for older people.

Before the inspection we looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. We looked at information held about the service such as complaints and whistle blower alerts. We also contacted Sandwell local authority who purchase services on behalf of people to see what information they held about the service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with 17 people who lived at the home and 11 relatives. We also spoke with one visiting health and social care professional and an Advocate. We spoke with the deputy manager, two nurses, nine care staff, the activities coordinator and the provider.

Some people's communication needs meant that they were unable to verbally tell us how they found living at the home. We observed how staff supported people throughout the day. As part of our observations we

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

We looked at the care records of seven people, the medicine management processes and at records maintained about staffing, training, accidents, complaints, surveys and the quality of the service, to include monitoring reports from the local authority and Clinical Commissioning Group, (CCG).

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe. One person told us, "Yes definitely feel safe and secure here. The staff come and check and see to me regularly and that makes me feel nice and safe and secure". Another person said, "I am safe here. They [staff] help and support me to walk as I can't walk well and that makes me feel safe to get around the home". A visiting relative told us, "He is very safe here. The staff are wonderful; they are always available, he has a buzzer to summon help, oh yes quite safe".

Staff knew their responsibilities to keeping people safe and how to report safeguarding concerns. Training records confirmed all staff had regular training in this area. One member of staff told us, "We all know how to escalate concerns to the senior or the [registered] manager". A visiting health professional told us, "The [registered] manager is very open and honest and if staff are doing something wrong she will safeguard and let us know. If something could have been avoided she will let also let us know". The registered manager had an established system for reviewing records of investigations into safeguarding or accidents and incidents. The Local Authority monitoring report advised us improvements were needed for people's safety in relation to supporting their fragile skin when seated. During our visit we saw these improvements had been implemented; for example the provider had purchased in-situ slings. These are slings which people can remain sitting on between hoisting because they have properties that do not cause friction to people's fragile skin.

Staff were aware of risks to people's health and safety and how to manage those risks. One person was at risk of urine infection due to a medical complaint. We saw their risk assessment was reviewed monthly alongside the affects of their medication. Another person had been referred to speech and language team (SALT) for risks related to choking and guidance for staff to support them safely was in their care plan. We saw a person who was being assisted to move with equipment and they told us, "When I'm hoisted I do feel safe". Staff were well informed of emerging risks to people as these were shared at each shift change. We saw that each staff member had a handover sheet which had been updated with any relevant information related to supporting people safely; for example how frequently they needed their position changed, if they were poorly or if their mobility had decreased.

People told us and we saw that there were enough staff available to meet their needs. One person told us, ""Yes certainly is. I have been in several other care homes and this is by far the best one with staff always readily around for me". A relative told us, "I would say yes to that. Not only do the carers come to her regularly but also the nurse as well and I have noticed staff are always passing by her room with her door open and always ask if she is ok". We noted that call bells were rarely used; staff frequently visited people in their rooms and attended to their needs. People told us if they did use their call bell in their room that staff responded in a timely manner. A relative said, "There are always plenty of staff about, I've never heard any call bells going off". Another relative said, "I have never visited here and thought that there were not enough staff on duty. Dad would also say if he thought he wasn't being attended to, yes quite happy with staff levels, there are a lot of staff". Staff we spoke with told us that they were happy with the staffing arrangements. The registered manager used a staffing tool to help determine staffing levels and this was regularly reviewed.

The provider had robust recruitment practices to ensure staff employed were safe to support people. Discussions with staff and sampling of records showed that checks included obtaining a Disclosure and Barring Service Check (DBS) and securing references from past employers. This helped to ensure people were supported by staff suitable to work in Adult Social Care.

We saw that people's medicines were stored and administered in a safe way. The majority of balances we checked were accurate indicating that people had received their medicines as prescribed. There were a couple of occasions where the balance did not match the records but we did not see any impact on people from this. The nurse told us they would review to ensure staff were recording correctly when medicines were administered or refused. Staff who administered medication had been trained to do so and there was a system in place to assess staff competency. Prompt engagement with healthcare professional's ensured people had their anticipatory medicines in place to manage pain when they needed this. Nurses we spoke with reviewed medicines monthly and demonstrated that action was taken when people's needs changed. For example a person's blood sugars had spiked as a relative had given them sweets and the nurse explained what they had done to manage this. We saw from records that blood sugar levels had been reduced as a result of this.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the right training and skills to meet their needs and that they were happy with the way staff cared and supported them. One person told us, "Yes the skills and knowledge of all the staff here are excellent. I have a medical condition and they all know this and I need a lot of water and they are constantly checking to ensure my glass by the side of me is always topped up". Another person told us, "Definitely. I am on oxygen and they are always ensuring that the equipment is running right and that I have the right amount". A relative told us, "They have sorted out his medicines and his eating; he never hardly ate at home. He is well happy here, pain free and eats well so full credit to them all".

Staff confirmed they had a detailed induction where they worked alongside experienced staff to ensure they developed the skills and knowledge needed to support people. Staff members told us that their competencies were checked following induction to ensure they were working to the required standards.

People were supported by staff that had the skills and knowledge to meet their needs. We saw a structured training programme was in place which ensured staff received regular updates and additional training to meet the specific needs of people. For example some staff, including a domestic staff member, had all received 'First Responder Training' with a view to responding effectively to emergency health needs. It was agreed the domestic should do this training because; "They are in and out of people's rooms and may be first on the scene'. A community nurse told us, "This training has definitely had an impact; the first month after having training a member of staff was first on the scene to a person having a cardiac arrest. They told me they felt very comfortable dealing with the situation". We saw the provider had employed a qualified specialist in palliative care as their lead nurse. They would support other nurses with syringe driver management; [a system for administering medicines to manage pain] and training in this area for other the nurses had been booked. We saw the provider had also appointed Dignity Champions within the home. This ensured that staff had the skills to protect and promote people's dignity.

All the staff we spoke with told us they felt supported in their role and that they received regular supervision to reflect on their care practices. Regular staff meetings provided staff with opportunities to reflect on their practice and receive updates. One staff member told us, "Management are very good; if we need any support it is provided".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff understood the importance of seeking people's consent and we saw they did this before they assisted them with their care needs. One person told us, "They always ask me if it's alright before they do anything". Another person said, "They do ask and if I don't want them to assist me they accept that". People confirmed that they made their own decisions and choices about daily living and routines. The provider had taken action to ensure staff had the skills and knowledge to deliver effective care; for example, a relative told us, "Mom's dementia is getting worse but they are well aware of that. Also with the carers whose first

language is not English they look and watch how they react with her to make sure they fully understand her needs". This ensured that potential language barriers were addressed so that where people do not have the capacity to make decisions, they are given the information they need in a way they understand and can respond to.

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 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. Capacity assessments were in place where people were unable to make specific decisions. We saw best interest meetings had taken place to include relatives and relevant health care professionals to ensure any decisions made on people's behalf were in their best interests. A relative told us, "I have never seen anyone being stopped from doing something they like". We found that applications had been made to the local supervisory body for DoLS as required and in line with the legislation. All the staff we spoke with were aware any restrictions on people's liberty and how to manage these. There was a keypad entrance on the dementia unit but we saw where people had capacity the code was shared with them so that they were not restricted.

Everyone we spoke with was complimentary about the quality of the food and said the choices particularly at teatime, had improved. One person told us, "The food is very good and you get a good choice". Another person said, "The food is good, they always ask what I want". People were consulted on a quarterly basis to ensure menus met their choices. Staff demonstrated that they knew each person's needs and preferences in terms of food and drink and the chef had a clear understanding of people's nutritional needs. We observed the consistency of people's meals matched the information in their eating plan which ensured people had food that was safe for them to swallow. Staff were aware of people who had complex needs and could be at risk of poor nutrition. Staff were frequently promoting snacks between meals; with a variety of cake, biscuits and crisps, regularly offered. We saw a person who had a poor diet, was encouraged to eat small quantities by staff. The staff member had a small orange at her desk, ready for this person and when she thought she might be able to tempt her with it, offered it, peeled it and the person happily accepted it and enjoyed it. People had the appropriate support to manage their meals; staff conversed with people and prompted them. We saw a variety of regular drinks were also offered to people. Systems to monitor people's weight helped to identify those at risk and we saw appropriate action was taken to ensure people had prescribed supplements to support their nutritional intake. Where people may require meals appropriate to their cultural or religious needs, these could be catered for.

People continued to be supported with their health care needs via access to health professionals. One person told us, "I never have any worries; there are nurses here, the doctor comes in and if I need anyone else they arrange it". We saw that each person had a health passport which identified their health needs and how these should be managed. Grab and Go folders had been devised in conjunction with West Midlands Ambulance service so that essential information was available in an emergency. A visiting community nurse told us the service regularly made referrals to speech and language therapists, physiotherapy, occupational therapy and specialist nurses. She was complimentary about the service stating the registered manager was very receptive to suggestions for change and she had seen over the last few years how the service had, "Just got better". Nurses we spoke with had a clear system of working to include the delegation of clinical tasks. This ensured people had their wound dressings and other health needs attended to at the right frequency.

Good

Is the service caring?

Our findings

People who lived at the home told us that staff were caring. One person said, "The carers [staff] are excellent I can't fault them, they are always checking on me and make time for a natter". Another person told us, "The staff here are really, really lovely. They are always popping in to see me, helping me to do things and quite cheerful and chatty with me". Relatives were very positive about the caring approach of staff; one said, "The staff here are exceptionally good; they're polite, friendly and caring and take time out with him".

We observed positive interaction between staff and people who used the service and saw that staff were considerate and helpful. For example, a staff member offered to charge a person's mobile phone and to check for missed calls. As staff walked round the units they acknowledged people and visitors and exchanged a few words with them. After lunch we heard a staff member say to people if they would like to, "Sit in a comfy chair and have a cup of tea". We saw another staff member asked if people wanted to watch a film and what they would like then searched the TV guide until she found a film they all enjoyed. We saw staff were alert and responded to people's distress; a member of staff noticed a person who was upset and crouched down to eye level and comforted her until she got her laughing. Staff spoke warmly about the people they supported and had a good knowledge of their individual preferences. Health and social care professionals also confirmed that staff were kind and caring. We saw there was frequent contact with people which everyone commented upon; we saw staff sitting, talking and listening to people on a regular basis.

People were supported to express their views and were involved in making decisions about how their care was provided. We saw staff regularly asked people how they wanted to be supported. People's care plans were personal to them and contained details about their preferred routines and preferences. Staff had explored what was important to people and what would comfort them and this was evident in the people's care plans. For example one read, 'Likes door open, curtains closed, speak slowly and crouch to eye level, keep photos and familiar effects in view'. It was positive to note that staff we spoke with were familiar with what was important to people and tried to mirror this when delivering care so that people received individualised support and care. People's independence and autonomy was promoted by the use of IPADS and access to WIFI.

People had been supported to access advocacy services and information about advocacy was available. Advocates are people who are independent and support people to make and communicate their views and wishes known. We spoke to a visitor from Sandwell Advocacy who told us that people were supported to exercise choice. They told us there was always a nice feel about the home and that they had a high regard for the staff who engaged with their service positively.

People who lived at the home and their relatives told us that visitors were made welcome and they could visit at any time with no restrictions. One person told us, "Yes my family come and visit me every day and can come and go when they want to". A relative said, "I can call in to visit her at any time I like to".

People said that staff respected their privacy and dignity. One person told us, "They are very considerate; keep me covered and never make me feel embarrassed". A relative told us, "Very respectful with him. Put

screens around him when bathing him and ensure he is well covered up". We observed staff were discreet when asking people if they needed assistance to use the toilet and we saw they adjusted people's clothing regularly throughout the day to protect their dignity. Many people were cared for in their bedrooms and told us that staff were respectful when entering and gave them privacy to see their families.

The provider was proactive in recognising the need for good end of life care. They had appointed a nurse as a palliative care lead and we saw that training was being established in Advanced Care Planning. This was to ensure the individual needs and wishes of a person at this time and any resources such as medicines for pain management or comfort aids, could be sourced. We saw for example anticipatory medicines were in place to manage people's pain. We also saw that end of life care plans contained both personal and clinical details as to the preferences and wishes of the person. There was recognition of the importance of comforting people and we saw that comfort items were identified and made available to people. Aromatherapy resources were on order which showed a commitment to supporting people's comfort at the end of their journey. A relative's room had been comfortably furnished and used by families so that they could be near their family member at the end of their life. We saw a number of compliments on display from families wishing to express their appreciation at the support they had received from staff. Comments included; "My husband spent his last four weeks at Ash Lodge receiving palliative care; staff showed great kindness and compassion and we were offered a room to stay overnight; nothing was too much trouble". This reflected compassion towards people and a commitment to developing this aspect of the service.

Good

Is the service responsive?

Our findings

People confirmed that staff were responsive to their needs. One person told us, "They help me with jigsaws, going out walking and on trips and even using an I-pad. I play noughts and crosses with the activity lady as well. They always ask what I would like to do and join in with me. I also have my nails done I like that". Relatives were very complimentary about staff responding to people's needs, one told us, "They get her to do pictures and drawings and have put a frame up in her room to put the pictures on". The provider informed us that display boards had been purchased for every room so that people could display any pictures or photographs that would bring them comfort.

We saw lots of examples that showed people were fully involved in the planning and review of their care. Care plans reflected people's involvement; for example one read, "[Person] tells me he won't eat much, but he does like hot food". Each care plan started with the perspective of the person and included information on a person's preferences and specific needs. Staff had a comprehensive knowledge of people; we observed the way staff responded to people demonstrated that they knew them well. For example, when a person became upset, staff knew how to respond, what to talk about, what distractions would work and we observed this taking place. A staff member told us how they compiled information on people's needs, "I've been observing [person] for a few days to check their mobility, they appear weak on one side, so we will discuss options such as contacting OT [occupational therapy] for advice. I like to watch [people] before I start the full care plan. If you watch you learn more".

There continued to be well established opportunities for people to participate in leisure interests and hobbies. People we spoke with told us they enjoyed the range of activities on offer. One person told us, "They take me to bingo and things they have on and put music on for me as I like that. I like going to watch the singers they have as well". Relatives told us, "He likes going to bingo, trips and doing puzzles and going on walks or 'pushes' as he calls it because he is in a wheelchair". There were regular visiting entertainers and planned celebrations for specific events as well as regular baking sessions. We saw people engaged in knitting, games, crosswords and puzzles, other people told us they enjoyed music and having their nails done which showed activities were personal to people's preferences and that one to one activity was provided and inclusive of those people who were cared for in bed. We also heard in good weather people participated in gardening. The activities coordinator arranged a variety of events and photographs displayed the activities people had enjoyed, this included pictures of "wishes" that people had made and had been supported with. We saw that organised events of interest had taken place. On the day of inspection some people were visiting the Sea Life Centre. There were established links with the local community with involvement from local Schools, colleges and churches. Fete's and fundraising events had taken place and trips to places of personal interest had been explored and fulfilled. This had included a trip to Nandos, Sandwell Valley and West Bromwich shopping Centre.

People told us they were aware of how to make a complaint and were confident they could express any concerns. Each person was supplied with a copy of the complaints procedure to aid their understanding. We reviewed the complaints file which contained an up to date policy and we found complaints were acknowledged, investigated and resolved to the satisfaction of the complainant. The deputy manager told

us complaints and concerns were taken seriously and used as an opportunity to learn and improve the service.

Good

Is the service well-led?

Our findings

Everyone was complimentary and described the service as being well managed. One person said, "Oh yes quite well managed it is all very good here and I am quite happy". Another person told us, "Yes and you can tell it is well run by how kind staff are and how clean and nice it is". A relative said, "Yes very much so. All [staff] are approachable; seniors and management". One relative told us they were kept informed of issues, they said, "All new relatives get an induction pack showing all costs, how to raise any issues, residents meetings and all the information you could possibly need. It is excellently run in my opinion".

The provider, registered manager and staff team all shared a clear vision and commitment to deliver quality care to people. This was evident with good links with other agencies to replicate best practice and sourcing training to extend and develop staff knowledge and skills around end of life care. Whilst they were still developing this aspect of the service, relatives confirmed that they had experienced good outcomes by benefitting from the facilities which had been created so they could be near their family member at the end of their life. A visiting health care professional told us, "It's a service you can see improving, the registered manager is open and transparent and both she and the provider are receptive to suggestions for change".

The registered manager was supported by a deputy manager, a team of nurses and care staff. We observed there were clear responsibilities and that tasks were delegated and all staff understood their role. All staff told us they felt supported by management and welcomed the training on offer. One member of staff said, "I have recently completed my NVQ 5. I want to do a workshop with staff and management have agreed to it and staff have agreed to come in on their day off". This showed there was a supporting culture at all levels which motivated staff. The registered manager and provider worked in partnership with external organisations such as the Providers Association. This is a platform for providers to discuss/reflect and identify new initiates/share ideas and explore best practice. The links with the external palliative care team as well as a range of health care professionals supported the provision of care by ensuring staff were up to date with best practice and that people using the service experienced good outcomes.

The registered manager understood their responsibilities to inform the Care Quality Commission of specific events. Where safeguarding issues, complaints or whistle blower concerns had been raised the registered manager had investigated and shared the outcome with the Care Quality Commission when asked to do so. This reflected an open and transparent culture. Staff were aware of the whistle blower procedures and were confident any concerns they raised would be acted upon. Whistle-blowing is the term used when someone who works in an organisation raises a concern about care practices which may cause harm to people who use the service.

Staff told us that management provided regular staff meetings, supervision and training. We also saw that guidance for staff was displayed to support their understanding of required standards and regulations they need to know such as duty of candour; [the provider's responsibility to be open when things go wrong], and Deprivation of Liberty Safeguards (DoLS). The registered manager was therefore ensuring staff understood what was expected of them and demonstrated that the leadership within the home had looked at ways to support staff's understanding.

People and relatives confirmed they had regular opportunities to give their views on the service by attending meetings and completing feedback questionnaires. We saw that people could also make comments and suggestions and that these were displayed in the main entrance to the home. We saw that information was available to people about the action taken in response to their suggestions. For example one person's comment related to nail care and we saw this had been acted upon. This ensured people felt they were listened to. A monthly surgery offered people the opportunity to meet with management to give people and families the opportunity to discuss their care or any concerns they may have. The provider also displayed a newsletter to keep people up to date with events within the service. This demonstrated that people's feedback and experiences had been used to drive improvement within the service.

The registered manager had continued to ensure they monitored the quality of the service. Information provided in their PIR matched the monitoring and audit processes we saw. For example regular audits of care plans, people's medication and equipment had taken place. Accidents, incidents, hospital admissions and falls had been analysed for patterns and any actions were shared with staff so that they could learn from these. We saw they had extended their audits to look at their performance in some specialist areas such as the use of antibiotics and frequency of people accessing specialist services external to the home. The audit looked at the service visited and the outcome of the visit. Nurses told us this allowed them to reflect on and follow best practice. Reports were seen from external monitoring visits to check and review the service and ensure that good standards of care and support were being delivered. The provider had acted upon recommendations to ensure the safety and wellbeing of people living at the home.