Macneil Limited

# Ashton Lodge Care Home

## Inspection report

Ashton Lodge,
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Date of inspection visit:
24 November 2016

Date of publication:
29 December 2016

## 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

The inspection took place on 24 November 2016 and was unannounced.

Ashton Lodge Care Home provides accommodation and nursing care for up to 92 older people. There is a garden to the rear of the premises. A large car park area is located at the front. The service is located close to Brent Cross shopping centre and public transport facilities.

The current registered manager had been in post for six month. 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 told us they felt safe at the home. Each care file included a dependency tool to calculate the level of need for each individual. This was used to inform staffing levels to ensure there were sufficient staff deployed on each shift. There were sufficient staff deployed on the day of the inspection. The recruitment process was robust to help ensure suitable staff were employed at the service.

Appropriate policies were in place with regard to safeguarding and whistle blowing. Staff had received training in safeguarding and those we spoke with were aware of the issues and confident of the reporting procedure.

Medication systems were robust and medicines were managed safely at the service. Individual and general risk assessments were in place.

Equipment was fit for purpose and was regularly serviced and maintained to ensure it was in good working order.

The induction programme helped ensure new employees were equipped with the skills, knowledge and competence to work at the home. Training was on-going and mandatory training was refreshed regularly.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA). Deprivation of Liberty Safeguards (DoLS) authorisations were in place where required and staff were aware of the implications of these.

People's nutritional and hydration needs were assessed and recorded appropriately. Special diets were adhered to by the chef and people were given choice with regard to meals.

People we spoke with felt the care was good and staff were kind and caring. We observed good interactions between staff and people who used the service throughout the day. People who used the service and their families were involved in discussions about the delivery of their care. Staff respected people's dignity and

privacy.

People who were nearing the end of their lives were cared for, as far as possible, in accordance with their wishes. Staff had undertaken appropriate training in end of life care and people's end of life care plans were thorough and comprehensive.

Care files we looked at evidenced that care was delivered in a person centred way, taking into account people's preferences, likes and dislikes. People we spoke with said staff responded quickly to call alarms.

There was a programme of activities at the home and people were encouraged to participate if they were able to. One to one interaction was undertaken with people who were unable to participate in group activities.

There was an appropriate complaints policy and this was displayed throughout the home. Concerns were responded to in a timely and appropriate manner and the service had received a number of compliments and thank you cards.

People told us the staff and management were approachable. Staff felt the registered manager was supportive towards them. Regular team meetings were held, and staff were given supervisions on a regular basis. Residents' and relatives' meetings were also in the process to be arranged for the beginning of December 2016.

We saw evidence of regular checks and audits that took place at the service to help ensure continuous improvement with regard to care delivery.

## 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. People told us they felt safe at the home.

A dependency tool was used to calculate the level of need for each individual and help ensure sufficient staff were on duty.

The recruitment process was robust. Appropriate policies were in place with regard to safeguarding and whistle blowing.

Medication systems were robust and medicines were managed safely at the service. Individual and general risk assessments were in place.

### Is the service effective?

Good

The service was effective. The induction programme helped ensure new employees had the right skills and knowledge to work at the home. Training was on-going and mandatory training was refreshed regularly.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional and hydration needs were assessed. Special diets were adhered to.

### Is the service caring?

Good

The service was caring. People we spoke with felt the care was good and staff were kind and caring.

We observed good interactions between staff and people who used the service throughout the day.

People who used the service and their families were involved in discussions about the delivery of their care. Staff respected people's dignity and privacy.

Staff had undertaken appropriate training in end of life care and people's end of life care plans were thorough and

comprehensive.

## Is the service responsive?

Good

The service was responsive. Care files evidenced that care was delivered in a person centred way and people we spoke with said staff responded quickly to call alarms.

There was a programme of activities at the home. One to one interaction was undertaken with people who were unable to participate in group activities.

There was an appropriate complaints policy and concerns were responded to in a timely and appropriate manner.

## Is the service well-led?

Good

The service was well-led. People told us the staff and management were approachable and staff felt the manager was supportive towards them.

Regular team meetings staff were given supervisions were held and there were residents' and relatives' meetings planned.

We saw evidence of regular checks and audits that took place to help ensure continuous improvement with regard to care delivery.

# Ashton Lodge Care 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.

The inspection took place on 24 November 2016 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC), one CQC pharmacy inspector, two professional advisors and one 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.

Before this inspection we reviewed the previous inspection report and notifications that we had received from the service. We reviewed all of this information to help us make a judgement about this service.

During our inspection we looked around the building. We spoke with the registered manager, the operations manager, and 20 members of staff, which included registered nurses, senior care workers and care workers. We spoke with eleven people living at the home and with three relatives.

We looked at records at the service, including 12 people's care records and records relating to the management of the service including policies and procedures, maintenance, quality assurance documentation, staff training, supervision and appraisal records and the complaints file. We reviewed 60 Medicines Administration Records (MAR) and four additional care plans relating to medicines, audits and training information.

Good

# Is the service safe?

## Our findings

People who used the service told us "It is safe here; I never have to wait when I need some help." One relative told us "They monitor my relative and ensure that she is safe." Another relative told us "They have a good team here who know the patients, but recently they have moved around a lot." A member of staff told us "We make sure that all our residents are safe and if there is something out of the ordinary we will report it to [manager's name]."

We looked around the home including bedrooms, communal areas, bathrooms and toilets. We found the premises to be clean and fresh and there were no unpleasant odours. One person told us, "I have nice room with all my own belongings, I like to spend most of my time in my room".

The service had appropriate safeguarding and whistle blowing policies. Staff had received training on how to identify abuse and understood the procedures for safeguarding people. Staff were able to describe the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place. Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately. They told us they could report allegations of abuse to the local authority safeguarding team and the Care Quality Commission (CQC) if management staff had taken no action in response to relevant information.
Staff were aware of whistleblowing. We looked at the way the service dealt with safeguarding concerns. There had been one recent concern, which was regarding two people living at the home. We saw that there had been a thorough investigation and the service had followed up with actions, including discussions with staff to minimise the risk of similar incidences happening in the future, staff training and a staff meeting to discuss the concern.

Care files included appropriate individual risk assessments relating to areas such as nutrition, falls and moving and handling. All accidents or incidents were monitored to look for patterns or trends which could be addressed by the management. Call alarm use had been assessed and contingency plans were in place for those who were unable to use an alarm, such as checking on them regularly and anticipating their requirements.

We saw records and risk assessments were in place for all areas of the general environment and policies were in place for ensuring compliance with health and safety regulations. We saw that equipment had been serviced in line with the manufactures instructions. We saw systems were in place in the event of an emergency such as utility failures and other emergencies. There were personal emergency evacuation plans (PEEPS) in place, so that people's individual needs in an emergency would be known. There was a central PEEPS file near the entrance to the home for easy access.

Each individual care file included a dependency tool. This was a tool used to calculate the level of dependency of the person to be used to inform staffing levels. We saw that staffing levels were sufficient to meet the needs of the people who currently used the service. Staff included the registered manager, registered nurses, care workers, activity coordinators, housekeepers and catering staff. The registered

manager told us they brought in extra staff if the needs of a person who used the service deteriorated and they required more assistance. We spoke with staff some told us that more staff would be required, but the majority of staff we spoke with told us that the staffing levels were sufficient to meet the needs of the people living at the home. People who used the service also felt staffing levels were sufficient to meet people's needs.

We looked at seven staff personnel files and saw a safe system of recruiting was in place. The recruitment procedures were robust to help protect people who used the service from being cared for by unsuitable people. The staff files contained proof of identity, an application form that documented a full employment history, a medical questionnaire, job description and two written references. Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with vulnerable adults and informs the provider of any criminal convictions against the applicant.

Medicines were managed safely in the service. Medicines were stored securely and appropriately in each clinic room. Staff checked and recorded temperatures daily to ensure medicines were kept within the correct range. Controlled drugs were stored, recorded and administered safely in line with the service's policy. Medication administration records (MAR) were clearly completed showing that people received their medicines as prescribed. Additional information such as allergies, how people liked to take their medicines and photographs to aid identification was kept with the MAR.

All medicines that we checked were available for people. Some people had medicine prescribed to be taken 'when required'; a care plan to support this was kept with the MAR so that staff could administer the medicines consistently when people needed them. We saw that specific instructions were added to the MAR to help staff support people; for example we saw one person had a pain relieving medicine 'every morning before personal care'.

Creams and external preparations were kept safely in people's rooms and the use of these was recorded by care staff on a topical MAR which had a body map with it to illustrate where the cream was to be used.

Some people had difficulty swallowing their medicines. Registered nurses, the GP and pharmacy worked together to ensure they got their medicines appropriately. Where thickening powders had been prescribed to help people with swallowing, there were clear instructions for staff to ensure the correct thickness was used. Some people were assessed as not having the capacity to make their own decisions about medicines. In these cases a best interests decision was made and medicines administered covertly (disguised in food or drink), following clear instructions from the pharmacy.

A GP visited the care home weekly and when needed. The GP reviewed people's medicines regularly and recorded changes clearly for staff to follow. A local pharmacy supplied the medicines and attended the service to check in the monthly order and ensure there were no discrepancies.
A system of internal and external audits ensured the service maintained safe practice. Where concerns were raised in the audits we saw that actions had been put in place to address them. All nurses and senior healthcare assistants had been trained in medicines management and the manager had planned competency reviews. We saw staff giving people their medicines in a safe and caring manner.

Audits were undertaken around cleaning and maintenance and any issues identified were followed up appropriately. This was confirmed by the documentation we looked at. Infection control policies and procedures were in place and regular infection control audits were undertaken and infection control training was included in the staff training programme. We saw staff wore protective aprons and disposable gloves for different tasks including when carrying out personal care. Liquid soap and paper towels were in

communal bathrooms and toilets. This helped prevent the spread of infection. There were first aid boxes located on all floors. We saw records of regular checks of the contents, which were complete and up to date.

Good

# Is the service effective?

## Our findings

People who used the service told us "The food is wonderful. The meals are lovely", "The food is good" and "The food is fine. They know what you like." One relative told us "The staff is very good here, they know what they are doing and care for my relative very well." A member of staff told us "training has been excellent. The new manager is committed and she is making sure we all have the training we need."

The service was committed at developing staff skills through training. Staff had received relevant training to carry out their responsibilities in providing people with the care and support they needed. They were supported and encouraged to complete a variety of training including, health and safety, safeguarding, medication administration, respect and dignity and food hygiene. We found staff to be knowledgeable in relation to these areas.

We saw that on commencing work at the home all newly employed staff completed an induction programme. It contained information to help staff understand what was expected of them and their roles and responsibilities. We saw that a training matrix was in place to ensure that staff received the essential training to equip them to safely care and support people who used the service. Staff members we spoke with told us training was on-going and mandatory training was regularly refreshed.

Staff told us supervision had improved since the new manager took over. They told us this had become more regular.  Staff were not aware what a 'development plan' was. We spoke with the registered manager who was aware of this gap. She told us that she had devolved performance management to different levels of management to ensure all staff received supervision regularly. An appraisal plan was also in place for all staff. The registered manager stated she wanted supervision and appraisal to be a two-way process so staff were empowered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that capacity was assessed for each decision required and appropriate documentation was kept in the care files. DoLS applications had been made appropriately and documentation was in place. Staff we spoke with had undertaken training in MCA and DoLS and they demonstrated an understanding of the principles and application of MCA and DoLS.

We saw, within the care files we looked at, that consent or agreement documents had been signed, where possible, by the person who used the service. These related to the use of bedrails, photographs and agreement to the care and treatment provided. If the documents had been signed by someone else there was an explanation of why this was, for example, if the relative had Lasting Power of Attorney (LPA) and therefore had the authority to sign on an individual's behalf. Appropriate paperwork relating to LPAs was kept in the files.

We asked staff how they gained consent for care interventions from people who used the service. They told us they always asked, if the person had capacity. If not, they would use non-verbal communication, such as body language and facial expression to ascertain whether people were accepting or not. They explained how they gave simple choices to people who lacked capacity, so that they still had some control over their lives.

Do not attempt cardiopulmonary resuscitation (DNAR) forms were in people's care files and included clear documentation about whether the individual had been involved in discussions about this. If they had not been included, the reasons for this were documented and decisions had been made in consultation with the appropriate people to help ensure the decision was in the person's best interests.

People's nutritional and hydration requirements had been recorded within their care files and their risk of malnutrition or dehydration assessed. Appropriate referrals to other agencies, such as dieticians, had been made in a timely manner if required.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. People told us that the chef came around regularly and spoke to people to get an understanding of their likes and dislikes. Kitchen staff were aware of any special diets required including pureed or soft diets. They were knowledgeable about how they fortified food for people who needed a high calorie diet. We saw there were sufficient supplies of fresh and dried food available.

We saw each person had a jug of water in their room and refreshments could be made at any time of the day. Each floor had a small kitchenette located in the dining room. We looked at the menus and saw that choices were available at each meal. Alternatives were also available. Staff spoke with each person and asked what they would like to eat. One person requested baked potato which was not on the menu that day and this was provided.  People who used the service told us the food was "excellent" and there was plenty of it.

Records were completed after meals to monitor food and fluid intake. All people living at the home had a food and fluid assessment by the Speech and Language Therapy (SALT) team in relation to the risk of inadequate nutrition and hydration. These were in place as the home was caring for very frail and poorly people and monitoring was an essential part of their daily care. This ensured people were sufficiently monitored and managed. This was important because most people receiving care were at risk of poor nutrition and dehydration.

Good

# Is the service caring?

## Our findings

People who used the service told us they liked the staff; comments included. "Most of the girls are very nice", "The care is very good", "Staff is very nice, very helpful, very kind, very unassuming. I wouldn't say a bad word against them" and "The staff are very good to me, very very helpful."

Staff took into account people's individuality and their diverse needs. Staff took time to find out what people enjoyed and went out of their way to provide for people's preferences. For example half of the people are from Hindu faith. The home has a designated room where religious ceremonies were held every Thursday; these were well attended by people who used the service and relatives.

Staff demonstrated enthusiasm and were keen to engage people in activities. For example the activity coordinator spoke to all people who used the service to find out their interests, likes and dislikes. One member of staff described how people joined in with activities and became animated. The staff member told us "[name] is new to the home, she played and really enjoyed taking part in all activities offered" and "[name] responds well to music that she used to dance to."

The activities co-ordinator demonstrated how they had engaged with the local community. The home was visited by pupils from various schools and representatives from various faith groups, which included a Roman Catholic priest, an Anglican reverend and a local Iman.

Staff were skilled in communicating with people even when people were unable to communicate verbally or effectively. We saw that staff responded to people's body language and took care to ensure that people understood what they were communicating. For example during lunch one person began to show signs of agitation, we observed that the staff helping them with their meal provided reassurance and talked about things they enjoyed. This had the effect of calming the person enough for them to eat and enjoy the rest of their meal.
MAR charts also had recorded people's preferred name and we saw this was being used, sometimes a family or cultural diminutive that people preferred. Staff told us how they had learnt a few words in Mandarin to be able to have some communication with one person.

People's dignity and right to privacy was protected by staff. One person told us "[Staff] help me to get washed and dressed, they keep my dignity, they put a towel round me and make sure the curtains are shut." We observed that people were asked discreetly if they would like to use the bathroom and when people were assisted in moving from their chair the staff explained how they would be moved and encouraged them to assist themselves.

People told us they felt listened to. People had told the registered manager that meal times were being interrupted by other people's visitors. We saw that the registered manager had introduced a protected meal time, where visitors were asked to avoid visiting at mealtimes unless they were assisting their relative with their meal. One person told us "It's much better now." We observed that the lunchtime meal was calm and free from interruptions. We observed relatives who had arrived during lunch waited until after the meal had

finished before they joined their relative.

People's relatives and friends were made to feel welcome. One person told us "my daughter visits daily, she is made to feel most welcome." Records showed that staff had collated information about people's life history and their current likes and dislikes. Staff demonstrated that they knew people by the way they spoke with them by including items of interest such as their hobbies or family names and provided their drinks how they liked them without asking them every time.

Good

# Is the service responsive?

## Our findings

One relative told us that there has been an "Outing to Brent X and tea in a garden centre during the summer months." Another relative told us "They always tell me when they have any celebrations like Diwali Easter, birthday or Christmas and I am invited to it." One person told us "I talk to carers regularly about what they can do for me, I feel like I am involved." A relative told us "They always tell me if there is anything wrong and ask us if we would like to have anything changed."
The new registered manager overhauled the care planning system following an audit she undertook when she commenced employment. She told us that care plans were not fit for purpose and not user-friendly. This resulted in her implementing together with staff a care plan system which benefited staff, but ultimately ensured that people were cared for in accordance to their needs and wishes. We found very positive examples of this during our inspection, for example less people were confined to their room.

People's needs were assessed prior to their admission to the home. The registered manager visited people in their care setting to assess their needs and establish whether Ashton Lodge Care Home could meet their needs. Initial risk assessments and care plans were put in place and updated in response to their changing needs.
People's assessed needs were met in line with their detailed care plans. Staff carried out regular reviews of peoples' assessments and care plans and there was clear communication between staff to update them on any changes in care. For example the new registered manager had implemented a 'sitting out plan' which was linked with the persons care plan. This ensured that people were encouraged to get off their beds and sit in a chair, sofa or wheelchair depending on their needs. We observed this throughout the day and noted that it had been recorded in the person's daily records.
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Where people were at risk of falls, we observed that staff followed people's plans of care and were vigilant in observing them when they mobilised. One person had a device that alarmed when they stood up from their bed.

People had been involved in planning and reviewing their care when they wanted to. People's care and support needs were accurately recorded and their views of how they wished to be cared for were known, for example the time they wished to get up in the morning, their clothing and lighting in their rooms at night.

People's care and treatment was planned and delivered in line with their individual preferences and choices.

People were offered activities that responded to their needs. We saw people took part in and enjoyed the activity that was arranged on the morning of our inspection. There was an activity plan displayed on each lounge. These included reminiscence, bingo, reading the paper, exercise and some arts and craft sessions.

One person told us that there had been a religious service held on the morning of the inspection. "I did not want to join in the service, so it was best I went to my room." In the reception area there was a sign advertising this religious service, indicating that everybody could take part and visitors were invited.

We spoke with staff about how activities were decided in the home. They told us the activities person asked people on an individual basis whilst updating their previous life history. People were also asked about the activities they preferred through the regular 'residents and relatives' meetings and through regular quality questionnaires.

We spoke with staff about what activities people preferred to do. They told us that some people liked to walk outside, and we saw the garden was secure and included seating and a patio area for this purpose. Staff also told us other people enjoyed painting and playing games, and added that an activities plan was in place, but if people wanted to do something else, then staff would provide alternatives.

People had their comments and complaints listened to and acted on, and felt assured that the registered manager would take appropriate action. People had the option to complain in person at care reviews or at residents meetings, or in writing. There had been a number of complaints since the new manager started and we found that these had been investigated and responded to appropriately. A complaints procedure was available for people who used the service. People said they were provided with the information they needed.

Good

# Is the service well-led?

## Our findings

People were supported by a team of staff that had the managerial guidance and support they needed to do their job. The registered manager was visible and approachable and when the provider visited they took time to speak both to the people living in the home and the staff. We saw that people were comfortable and relaxed with the managers and all the staff. All the staff we spoke with demonstrated knowledge of all aspects of the service and the people using the service.

People who used the service made positive comments about the new registered manager "The home is well run", "I have no problem with the managers" and "The manager is approachable". Staff spoken with made similar comments "I am very happy since the new manager started, she is the best of the best", "The manager listens to us all the time, she is very approachable" and "I am very happy with the manager she listens and is very approachable."

People living at the home and their relatives were encouraged to provide feedback about their experience of care and about how the home could be improved. Regular audits and surveys were undertaken and these specifically sought people's views on the quality of the service they received. People were generally happy and content. The activities co-ordinator was given time to speak with people to gather any feedback. The registered manager told us that she was in the process of developing a monthly newsletter to provide people and relatives with information on forthcoming events and sharing past events.

It was evident that the staff worked well together as a team. At the daily handover meeting all staff contributed to how things had gone on the previous shift and how people were. There was a genuine commitment from all the staff to ensure they were providing the best possible care. There was a culture of openness and a desire to continually improve to provide the best possible person centred care and experience for people and their families.

There were systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. People were assured of receiving care in a home that was competently managed on a daily as well as long-term basis. Records relating to the day-to-day management and maintenance of the home were kept up-to-date and individual care records we looked at accurately reflected the care each person received.

Staff understood their responsibilities in relation to 'whistleblowing' and safeguarding and there were up to date policies and procedures to support them. People's care records had been reviewed on a regular basis and records relating to staff recruitment and training were fit for purpose. Records were securely stored to ensure confidentiality of information.

Quality assurance audits were completed by the registered manager. The provider made regular visits; some unannounced. The audits and visits helped to ensure quality standards were maintained and legislation complied with. Where audits had identified shortfalls, actions had been carried out to address and resolve them; for example the new registered manager undertook a full audit when she commenced employment.

She found that the care planning system was not fit for purpose and has completely overhauled and changed the care planning system. We saw that the majority of care plans had been updated; however the registered manager told us that this would be an on-going process.