Care Quality Commission

Parkview Care Homes Limited

Asher Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Asher Nursing Home on the 30 June and 2 July 2015. Asher Nursing Home is a mental health nursing home providing care and support for people living with enduring and complex mental health needs. The home can accommodate up to 17 people. On both days of the inspection, 17 people were living at the home. The age range of people varied between 35 – 86 years. Predominately people required support with their mental health; support was also needed in relation to diabetes, pressure care and physical disability.

Accommodation was provided over three floors with a lift and stairs connecting all floors. Located in Hove, the home provides access to the city centre and seafront. There is good access to public transport. During the course of the inspection, people were seen coming and going, going out to see friends, shopping or meeting family.

A registered manager was in post. 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 and associated Regulations about how the service is run.

People's safety was being compromised in a number of areas. Risk assessments failed to provide sufficient and

Summary of findings

robust guidance for staff to follow. For example, risk assessments failed to provide guidance on how to safely and effectively manager physical and verbal aggression. The management of falls required improvement as risk assessments failed to reflect the strategies and mechanisms required to reduce the risk of people falling. We have identified this as an area of practice that required improvement.

People's medicines were stored safely and in line with legal regulations. People told us they received their medicines on time, however, guidance for the use of 'as required' (PRN) medicines were not available. We have identified this as an area of practice that required improvement.

The requirements of the Mental Capacity Act 2005 (MCA) were not being adhered to. Mental capacity assessments were not completed and there was little consideration given to when a mental capacity assessment may be required. The care planning process had not given consideration to whether some people may be deprived of the liberty under the Deprivation of Liberty Safeguards (DoLS). We have identified this as an area of practice that required improvement.

Care plans were not personalised or centred on the person. Information was not readily available on the person's life history, how they perceived their mental health and what a good day looks like for them. People commented they were unaware of their care plan. One person told us, "I don't think I have a care plan." We have identified this as an area of practice that required improvement.

Improvements were required for the opportunities for people to engage with meaningful activities. The registered manager acknowledged further work was required to ensure people were stimulated and kept occupied. During the inspection, concerns were identified that people were at risk of social isolation. One person told us, "If it wasn't for the young staff, it would be hell here." We have identified this as an area of practice that required improvement.

Quality assurance systems were in place, such as health and safety checks but had not identified the shortfalls we found in the care delivery. Incidents and accidents were not monitored for any emerging trends, themes or patterns. We have identified this as an area of practice that required improvement.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Asher Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Staff members had a firm understanding of people's individual needs, personality traits and how best to support people. The level of knowledge held by staff was not reflected in the care documentation. Staff spoke with compassion for the people they supported and spoke highly of the registered manager.

Asher Nursing Home adapted an ethos whereby people's bedrooms were seen as their personal space. Many people before living at Asher had been homeless or in hospital for significant periods of time. Staff respected people's boundaries and privacy. People were encouraged to treat the room as their own personal space.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected. Staff spoke highly of the opportunities for training and received regular supervision.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

Asher Nursing Home was not safe. Risk assessments were not always in place and did not consistently reflect the measures required to keep people safe. People received their medicine on time, however, guidance was not consistently in place to ensure the appropriate use of 'as required' (PRN) medicines.

Systems were not in place to manage hot water temperatures which meant people were at risk of scalding themselves. Mechanisms had not been implemented to manage the hot weather.

People felt the home was sufficiently staffed. Staff had a firm understanding of adult safeguarding and recruitment systems were in place to ensure staff were suitable to work with people.

Is the service effective?

Requires improvement 

Asher Nursing Home was not consistently effective. The requirements of the Mental Capacity Act 2005 were not always followed. Decisions made on behalf of people were not made in consideration of people's rights.

People had mixed views about staff understanding of their mental health needs. Documentation did not consistently reflect when people last had GP or psychiatrist reviews. The management of diabetes required improvement.

The chef was committed to making the menu as varied as possible. Staff received regular supervision and spoke highly of the opportunities for training and on-going professional development.

Is the service caring?

Requires improvement 

Asher Nursing Home was not consistently caring. Positive engagement between staff and people was not consistent. People were not fully aware of their care plans. Individual goals were set for people but people were not consulted or included in the goal setting.

Staff members recognised and understood the importance of people's privacy and dignity. The home embedded an ethos whereby personal space was respected and staff always gained consent before entering someone's bedroom.

Is the service responsive?

Requires improvement 

Asher Nursing Home was not consistently responsive. Opportunities for social activities or engagement were limited. People also felt there was not enough to do at the home.

Care plans lacked personalised information and were not centred on the person. People were not consistently aware of who their primary nurse was.

Summary of findings

People's concerns and complaints were investigated, responded to promptly and action taken.

Is the service well-led?

Asher Nursing Home was not consistently well-led. Incidents and accidents were not monitored for any emerging trends, themes or patterns. Feedback from people was not used in making improvements to the running of the home. Mechanisms to scrutinise the running of the home required improvement.

People and staff spoke highly of the registered manager. Communication was valued by staff and staff spoke highly of working at Asher Nursing Home and spoke with compassion for the people they supported.

Requires improvement

Asher Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

We visited the home on the 30 June and 2 July 2015. This was an unannounced inspection. The inspection team consisted of two inspectors, specialist mental health nurse and an expert by experience, who had experience of mental health services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with six people who lived at the home, five care staff, two registered nurses, the chef, deputy manager, registered manager and the area manager.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Due to the mental health needs of people, we also spent time observing care practice in the communal dining room/lounge and sitting interacting with people.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at nine care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Asher Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Asher Nursing Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

The home was last inspected in September 2014, where we had no concerns.

Inadequate

Is the service safe?

Our findings

Most people told us they felt safe living at Asher Nursing Home. One person told us, "Yes, it's safe. I can do what I want, it's okay." However, due to some people's enduring mental health needs, they commented they didn't feel safe. People had mixed views about their safety and we found areas of practice which were not safe.

Risk assessments and risk management is an integral part of good quality mental health care. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. Each person had an individual risk assessment in place which considered aggression, fire safety and sexual and financial vulnerability along with other areas. Where people exhibited physical and verbal aggression, the risk assessments failed to record and reflect the measures required to control and manage the risk. Some people had a history of verbal and physical aggression towards staff and other people. The risk assessment recorded, 'Consistency and firm boundaries maintained.' No further information was recorded on what these firm boundaries consisted of or the triggers for the physical and verbal aggression. We spoke with staff in depth on how they managed aggression. One staff member told us, "We use de-escalation, get them away from the situation and talk about how they are feeling. We may also remove ourselves from the situation and implement boundaries, saying it is not appropriate to talk to us in that manner." The level of knowledge held by staff was not reflected in the risk assessments; therefore risk assessments lacked sufficient guidance and advice for staff members to consistently follow and ensure all staff were following the same agreed strategy.

Falls management required improvement. Falls risk assessments were in place, however, information was not documented on how to safely manage the risk of falls. One person had a history of falling out of bed. The risk assessment recorded, 'Has a history of falling off the bed as they sleep on the edge.' The risk assessment failed to reflect what mechanisms were in place or had been discussed to minimise the risk. Where people had a history of sexualised behaviour towards staff, clear management plans were not in place. One risk assessment recorded, 'Set boundaries as necessary. Educate in social skills.' The risk assessment failed to reflect what mechanisms were needed to safeguard staff, how staff could work with the person or explore what was causing the underlying behaviour. Staff members had a good understanding of the individual behaviours of people and talked about the mechanisms in place. One staff member told us, "We have to observe one person in the morning between certain hours to ensure they don't go outside during the school run." Staff had a good level of knowledge, however, risk assessments failed to demonstrate what work was being done with the individual to explore the behaviour and proactively work with the person to manage and minimise the risk.

We raised concerns with staff members regarding the management of certain behaviours. We looked at the daily notes for someone whereby it recorded a serious incident had occurred. Due to the significance of the incidence, police and child protection needed to be involved. The care plan for the person reflected an incident which had occurred last year and consequently certain strategies needed to be followed. We were unclear whether the daily notes were referring to the incident last year or a more recent significant incident as the daily notes recorded, 'a serious incident last week'. There was no incident forms completed and no documentation in relation to the daily note. The risk assessment had not been updated and only referred to the incident last year. No information was available on what other mechanisms were in place to ensure the risk was minimised. We asked staff for further information. Staff were also not clear. Due to the seriousness of the incident and the uncertainty regarding what actually happened, we requested the area manager undertake an investigation and look into the situation.

Systems were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. For example, weekly fire alarm tests and regular fire drills were taking place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan. Water temperature checks took place on a weekly basis checking the water temperatures of basins, showers and baths. On occasions in April, May and June 2015, we found water temperatures had exceeded 43c. For example, water temperatures were 44, 45 or 46c. Safe water temperatures within care homes

should not exceed 43c. Temperatures above 43c can place people at risk of scalding themselves. Where water temperatures had exceeded 43c, we could not see what action had been taken. Incidents and accidents confirmed no one had scalded themselves on the hot water, but the risk of harm could still occur.

On the first day of the inspection, the weather was extremely hot. Room temperature checks recorded that some people's bedrooms were 25, 26 and 27c. At 17.00, we asked the registered manager what action had been taken in response to the hot weather. We were informed the home didn't have any fans, but would be placing heaters into people's bedrooms and using the cold setting. We raised concerns that this action should have been commenced earlier in the day. Throughout the day, we regularly saw people sitting outside in the sunshine. One side effect of people's anti-psychotic medicines is an inability to regulate body temperature. We did not observe staff encouraging people to keep cool or use sun screen whilst outdoors.

Due to the above concerns in relation to poor risk assessing, lack of guidance and advice available for staff to follow, poor management of hot water temperatures and hot weather we have identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many people living at Asher Nursing Home dressed according to their life style choice and many people required support to manage and maintain their personal care needs due to risk of self-neglect. Self-neglect is a challenging area of practice, balancing the rights of the person against their right to self-determination. A failure to engage with people who are not looking after themselves, whether they have mental capacity or not, can have serious implications for the health and well-being of the person concerned. On the days of the inspection, we identified some people wearing stained and dirty clothing, we recognised that it may be a lifestyle choice but we also looked at their care plans to see if there was an element of self-neglect. Some people had been identified at risk of self-neglect and care plans recorded to, 'provide encouragement to attend to personal care needs and only offer support if the persons ask.' Recordings by staff on people's daily notes raised concerns regarding some people's personal care needs, with reference to their personal hygiene remaining poor and refusing to change clothes. The care plans failed to reflect what may be causing the person to self-neglect, if there were any strategies that don't work, strategies that do work and if the person was aware of the risks associated with self-neglecting. In April 2015, self-neglect was identified a safeguarding concern. There was no evidence of consultation with other professionals regarding how these needs could be met and the potential risks from self-neglect minimised. We spoke with staff members on how they engaged with people to manage their personal care needs. One staff member told us, "We have to build relationships with people first and get them to feel comfortable with us." Another person told us, "One person becomes upset if we talk about their personal hygiene, so we have to engage with them and work with them at their pace." It was clear staff had considerable knowledge of the needs of people and how to work with people; however, it was knowledge that was not reflected in people's care plans. Care plans and risk assessments also failed to reflect when the situation may reach a stage when safeguarding would need to be considered.

Due to the above concerns, in relation to self-neglect and safeguarding, we have identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, staff members had a firm understanding of positive risk taking and recognised the importance of supporting people to take risks. One staff member told us, "We want people to be more independent, so we often encourage people to take basic risks and this will therefore promote their independence." Some people were able to go out independently and we saw people coming and going throughout the day. One person told us, "Yes I come and go. I go and buy things."

People commented they received their medicines on time. One person told us, "Staff give it to me. The doctor explained the side-effects - like it gets you better but you put on weight. It's virtually the same time every day."

Medicines were stored safely. There was one dedicated locked clinical room which was appropriately equipped so that medicines could be kept safely. Medicines were ordered in a timely fashion from the local pharmacy and Medication Administration Records (MAR charts) indicated that medicines were administered appropriately. MAR charts are a document to record when people received their medicines. Records confirmed medicines were

Inadequate

Is the service safe?

received, disposed of, and administered correctly. Some medicines were 'as required' (PRN) medicines. PRN medicines can be prescribed for people with mental health needs to manage levels of anxiety, behaviour that challenges or periods of anxiousness. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. PRN protocols were in place which considered the reason for the PRN medicine, how much could be administered in a 24 hour period. However, information was not available on the steps to take before administering the medicine. One person's care plan recorded 'Early use of PRN.' PRN medicines should only be offered if all other steps have been taken without success. Guidance was not available. We have therefore identified this as an area of practice that requires improvement.

People and staff felt the home was currently sufficiently staffed but felt any less staff would not be satisfactory. Staffing levels consisted of one registered mental health nurse throughout the day and night. Three carers in the morning, two in the afternoon and two at night. We queried with the registered manager how they determined that staffing levels were adequate and based on the individual needs of people. The registered manager told us, "I listen to the feedback of staff. They previously told me that only two carers in the morning meant they had too much to do." We asked whether a systematic system was in place for determining the staffing levels such as a dependency tool. The registered manager confirmed they didn't complete one but had recently been told by the provider they needed to cut staffing hours for care staff. We raised concerns that without a systematic approach in place to determining staffing levels, how staff levels could be cut without first assuring that current staffing levels were adequate. We have therefore identified this as an area of practice that requires improvement.

During the inspection, we raised concerns about staffing levels in the afternoon. If someone wanted to go out and needed assistance from staff, that would only leave one staff member to cover the floor. Staff and management confirmed that if that occurred, currently one of the management team would cover the team. One staff member told us, "There are enough staff, but if there were any less staff, I don't think staffing levels would be safe." Another staff member told us, "We would struggle with less staff." Feedback from people felt there was enough staff currently. One person told us, "Yes, there's sometimes too many."

Staff were able to tell us confidently what they would do if they suspected abuse was occurring at the home. One member of staff told us, "I know how to raise a safeguarding concern if needed. It was clear staff understood their own responsibilities to keep people safe from harm or abuse. Safeguarding policies and procedures were up to date and appropriate for this type of home. Where safeguarding concerns had been raised, the registered manager had worked in partnership with the local mental health team to ensure protection plans were in place for people and any risk of future harm was minimised.

Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. Staff files contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed by Asher Nursing Home, bank nurses as well all had registration with the nursing midwifery council (NMC) which were up to date.

Requires improvement

Is the service effective?

Our findings

People commented they got along with staff members. One person told us, “Yeah they are ok.” We received mixed comments from people about feeling confident in the skills of staff and that staff understood their mental health needs. One person told us, “It’s dubious how much they understand.” Another person told us, “They don't understand me at all.”

The Mental Capacity Act (MCA) 2005 was designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. The philosophy of the legislation is to maximise people’s ability to make their own decisions and place them at the heart of the decision making. Staff members had a basic understanding of the legislation. One staff member told us, “It’s the person’s ability to make decisions, every decision is judged separately and its decision specific.” Another staff member told us, “The MCA came into force in 2007 and it’s about people who can’t make specific decisions for themselves.” During the inspection, we could not locate any mental capacity assessments undertaken by staff. One staff member inaccurately told us, “We don’t do capacity assessments here, we refer onto social services.”

During the course of the inspection, we regularly heard people asking staff for their cigarettes which staff provided. We were later informed that for some people, staff held their cigarettes. We could not locate any supporting documentation to confirm how these decisions were reached. There was no documentation recording whether the person consented to this arrangement or whether they lacked capacity for this specific decision and due to the risks involved, a best interest decision was made for staff to hold people’s cigarettes. One staff member told us, “Following a fire risk assessment, it was decided that people could no longer smoke in their bedrooms. We held a meeting and the fire officer attended and there it was agreed that people would hand in their cigarettes and everyone consented to this.” However, we identified that some people held their own cigarettes whilst staff held others. We asked staff how it was decided for them to hold some people’s cigarettes. One staff member told us, “Some people are at high risk of smoking in their rooms which is banned. Other people are not aware of the risks associated with continuously smoking; therefore for risk management we hold their cigarettes.” Staff members made no reference to the meeting whereby everyone consented. Where staff felt people were at risk, there was no mental capacity assessments in place to ascertain if they understood the risk or whether they wished to make an unwise decision. One person’s care plan recorded, “High risk smoker, committed an act of arson which caused considerable damage to their room. Staff will hold cigarettes and lighters.” How this decision was reached was not recorded. There was no documentation to suggest the person consented or whether it was agreed in their best interest.

For people who required support to manage their finances, there was no evidence of how decisions were reached for staff to hold people’s personal allowance or for the home’s administrator to manage people’s finances. One care plan recorded ‘Due to the person’s delusional state is potential to financial exploitation. Their finance has been managed through the home administrator with consent of their family.’ Under UK legislation, nobody can consent to something on somebody else’s behalf. We could not locate any supporting documentation to confirm whether the person had consented to this arrangement, if they lacked capacity to manage their finances and whether it was in their best interest for the home’s administrator to manage their finances. Documentation was also not available as to whether the home’s administrator had deputyship or legal powers to manage people’s finances. We spoke with the management team who identified that this arrangement had been in place for many years, even before the implementation of the MCA 2005. We were informed that the provider was the signatory for one person's finances; however, this arrangement had not been reviewed in light of the implementation of the MCA 2005. For some people, staff held their personal allowance. Documentation was not available to confirm whether the person had consented to this arrangement or whether due to financial vulnerability and the person lacking capacity to manage their finances, this was decision was made in their best interest. Staff members we spoke with confirmed some people would be at risk of financial vulnerability; therefore they hold people’s personal allowance and give the money when they request it.

Due to the above concerns, in relation to the absence of mental capacity assessments and evidence of best interest decisions, we have identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). In March 2014, changes were made by a court ruling to the Deprivation Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. If someone is subject to continuous supervision and control and not free to leave they may be subject to a deprivation of liberty. On the days of the inspection, we were informed that no one was subject to a DoLS authorisation. We identified a couple of people who had been placed at Asher Nursing Home in their best interest, were subject to hourly checks and required staff supervision to access the community. Whether people were subject to DoLS had not been considered as part of the care planning process. Consideration had not been given as to whether people could consent to the living arrangements, understood the reasons for the hourly checks and what was required to ensure they received regular support to go out and about. Training schedules confirmed staff had training on DoLS and staff had an understanding of what constituted a DoLS. However, we found full consideration to the Supreme Court Ruling had not been acted upon.

Due to the above concerns, in relation to assessing and considering whether people are subject to a DoLS, we have identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, staff had a firm understanding of the concept of consent and gaining consent. The registered manager told us, “We get people to repeat information back to us to ensure they’ve understood the decision.” Another staff member told us, “We always gain people’s consent and people have the right to refuse consent.” Staff gave examples of how they enabled people to make day to day decisions. Staff used the example of choosing what to wear and giving people options.

The management of diabetes required improvement. One person’s pre-admission assessment recorded they had unstable diabetes and required their blood sugars to be taken twice daily. This person had only recently moved into the home was regularly going out unsupervised. We requested to see the person’s blood sugars. Staff members confirmed they had not been undertaken since the person had moved in. The lack of daily blood sugars placed the person at risk of harm. Nursing staff had no oversight of their blood sugars and the person could have suffered high or low blood sugars. We requested blood sugars be taken immediately and on the second day of the inspection found documentation to confirm they had been checked and recorded. However, the risk to the person was high and therefore we have identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we also observed some good practice of diabetes management. Some people were insulin dependent diabetics but care documentation recorded they chose to eat unhealthy foods (regularly having takeaways). Documentation included clear information on what to do if blood sugars were over certain level and when to contact the diabetic unit. Information was available on insulin levels alongside the person’s level of compliance with insulin injections.

People were able to make choices about what they wanted to eat. People were asked each day what they would like for breakfast, lunch and dinner. One person told us, “There are three choices. We choose the day before.” We spent time observing lunchtime on both days of the inspection. On the first day, staff brought out meals to people; however, there was limited interaction between staff and people. For example, staff didn’t inform people what they had and if they were happy with the choice. On the second day, staff interactions were much more positive and staff interacted people in a friendly manner, enquiring how they were finding their meal. One person told us, “It was lovely today.”

The chef was committed to making the menus and food variety as personalised and unique as possible. The chef told us, “I put the menu together and I change it every six months. We do a food survey every three months, asking people what their favourite meal is. I also try and personalise the menu. We have meals such as Joe's Spaghetti Bolognaise and Susan's lasagne.” The chef was creative and innovative with meals ideas and commented on the pressures of working within the home’s food budget. The chef told us, “The food budget isn’t great. It works out at £1 per meal for each person. There are some food likes we cannot accommodate, such as lamb.” After speaking with the chef, we sought clarification from the provider who provided documentation which confirmed the budget was not £1 per meal for each person and was much higher than that. The provider confirmed they would liaise with the chef, to ascertain why they felt the budget was so low.

Requires improvement

Is the service effective?

A hot drinks trolley was available in the communal lounge/ dining room which enabled people to help themselves to hot drinks throughout the day. On a monthly basis people were weighed (with consent), this helped staff in monitoring people for any signs of weight loss or weight gain. Care plans also included a nutrition assessment (Malnutrition Universal Screening Tool) which looked at people's weight and BMI (body mass index) and identified if the person was at risk of malnutrition. Weight records demonstrated that people were maintaining a stable and healthy weight.

People had mixed views about staff's understanding of their mental health needs. One person told us "Yes they understand my needs." Another person told us, "I suppose so, they check you are ok." Whilst another person didn't feel confident in the skills of staff. We spent time talking with staff on how they effectively managed and met people's mental health needs. One staff member told us, "We have a good understanding of people's daily patterns, any changes in those patterns or changes in their presentation may indicate a decline in their mental health." Another staff member told us, "Many people have delusions and how we engage with people who are experiencing delusions requires tact. Sometimes we may go along with the delusion or try and engage with them on what's really going on." Staff members felt many people had improved since moving into Asher Nursing Home. One staff member told us, "One person was particularly aggressive, now they are much more settled and communicative." Another staff member told us, "One person is becoming much more independent and we now encouraging them to make their bed on a daily basis."

Staff members used the forum of daily notes to monitor people's health and wellbeing. Daily notes made reference to people's behaviour, levels of delusions and ideations. Daily notes were detailed which provided staff with an overview of how people had been on a daily basis. Each person also had a health care appointment diary in their care plan. This included information on when they last had a GP, dentist, optician appointment, when their next appointment was or when they last saw a psychiatrist or care coordinator. However, we found these health care appointment diaries were not consistently completed for everyone and it was not always clear when people had last seen their psychiatrist or had a multi-disciplinary review with the mental health team. We also found it hard to ascertain when staff had requested care coordinators reviews due to deteriorations in people's mental health needs or to review the effectiveness of the placement. One person's daily notes made regular reference to the person presenting as delusional but also presenting with strange behaviours. The care plan for the individual reflected they experienced 'continuous delusional ideas', however, information was not available on what behaviours may trigger the need for a psychiatrist review. Many people were on high doses on medication. One person was on two anti-psychotics, two anti-anxiety, one anti-depressant and one mood stabilising medication. We were unable to locate any evidence of a recent medicines review. Staff confirmed people had regular psychiatry reviews and GPs, however, documentation failed to reflect this. We have therefore identified the above concerns as an area of practice that requires improvement.

Staff felt regular training was provided and it gave them the necessary skills to undertake their role. Essential training was provided in a number of areas which included manual handling, health and safety, first aid and medication. Specific training was also provided which enabled staff to provide effective care to people with mental health needs. This included violence and aggression training and mental health awareness. Staff spoke highly of the opportunities for training. One staff member told us, "If there's any training I want to do, the manager will always arrange it for me." The registered manager recognised that supporting people with mental health needs was challenging and understood the importance of supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development. Staff commented they received supervision on a regular basis and found the forum extremely helpful. One staff member told us, "Supervision is both helpful and informative." The registered nurses received regular clinical supervision alongside clinical training to help keep up with their continuing professional development.

Requires improvement

Is the service caring?

Our findings

People felt staff respected their privacy. One person told us, “They're not too bad. I suppose so.” Another person told us, “Yes, staff talk to us.” Although people spoke positively of staff, we found areas of practice which were not caring.

Engagement and communication with people with mental health needs is a vital component of good mental health care. On the first day of the inspection, we spent an hour sitting in the communal lounge/dining room. During this time frame, there was limited engagement between staff and people. People were sat watching television, outside smoking, or sleeping. Staff spent no time sitting with people, engaging or interacting. On the second day of the inspection, interactions between staff and people were much more positive. Staff were observed sitting talking with people and regularly interacting with people. One person was becoming increasingly distressed and anxious. A staff member identified this and sat with the person providing reassurance alongside ascertaining what was wrong. The person appeared to relax and enjoyed the companionship of the staff member. However, due to the difference in observation observed, we raised concerns in relation to the consistency of staff interaction and engagement.

We recommend that the service considers the National Institute for Health and Care Excellence quality standard for service user experience in adult mental health.

Each person living at Asher Nursing Home had their own care plan. A care plan is something that describes in an accessible way the services and support being provided to an individual. We asked people if they were involved in the design and formation of their care plan. One person told us, “I want to get one (a care plan).” Another person told us, “I think so, I don’t use it though.” They then called out to the nurse, ‘do I have a care plan?’ to which the nurse explained what a care plan is. They then told us, “I haven’t seen it for a while.” Care plans themselves failed to demonstrate how the person was involved in the design. People were not signing their care plans to indicate consent and there was no information within the care plan from the person’s perspective on what was important to them.

Goal setting in mental health is an effective way to increase motivation and enable people to create the changes they desire. We spent time talking with staff on how they enabled and empowered people to achieve greater independence and possibly work on moving on from Asher Nursing Home. Staff members identified that due to the age of some people and the complexities of their mental health needs, some people would be unable to move on, however, felt people had the skills and opportunity to move on or learn new skills. Most staff feedback was that they would like to do more rehabilitation work and help people develop skills and move on. Staff members informed us one person who they were working with to move on. The person was learning to independently cook again and was going to the care home next door (same provider) to cook. Staff told us that the plan was for this person to move next door and receive further rehabilitation before looking at living independently in the community. We were informed that goals were set and included within people’s care plans. One person’s goal was to stabilise blood glucose levels. Another person’s goal included to manage and resolve pain in their ankle. Care plans were reviewed on a monthly basis however it was not clear if the person had met their goal or if further work was needed in order for them to achieve the goal. It was not clear the progress the person was making. We asked people if they felt they had achieved their goal, however, people were unaware of their individual goals set out in their care plan. One person told us, “I’m not aware of anything in my care plan.” One member of staff told us, “People should be involved in their care plans; the monthly reviews should take place with the person and hopefully their care coordinator. We could not find any supporting documentation to confirm this.

Due to the above concerns in relation to care planning and goal setting, we have identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Asher Nursing Home adopted an ethos whereby people’s bedrooms were their own personal space. Many people living at Asher Nursing Home had previously been homeless, spent months in hospital or not had their own space previously. Staff recognised the importance of empowering people to treat their bedrooms as their own and respected people’s personal boundaries and space. Throughout the inspection, we observed staff knocking on people’s doors and gaining consent before entering. If

Requires improvement

Is the service caring?

people were in the communal areas, staff gained their consent before entering their room if they needed to get anything. People commented they enjoyed having their space and felt staff respected this.

During the inspection, the inspection team spent time walking round Asher Nursing Home, sitting with people, observing care and talking. We found people at the home appeared at ease and relaxed in their environment. Some people were observed freely coming and going and told us how they enjoyed being able to go out independently. Staff members called people by their preferred name and staff interacted with people in a polite manner.

Staff members confirmed visiting was not restricted; people were welcome at any time. Staff confirmed they encouraged people to maintain relationships with those who were important to them and worked in partnership with friends and relatives to promote the wellbeing of people.

Requires improvement

Is the service responsive?

Our findings

People felt there was some opportunity for activities. One person told us, "I do painting here but we don't do something every day." Another person told us, "Play cards games." While another person told us, "'I do some painting, play on my computer and eat dinner." The management team and staff also recognised that more work was required to promote and engage people in meaningful activities.

Engagement with meaningful activities can help make people feel valued, help people develop new skills and promote their identity. For people with mental health needs, engagement with activities can provide structure and promote well-being. We asked what activities were on offer for people. An arts therapist visited every other week. People commented they enjoyed painting and their paintwork was displayed on the wall in the communal lounge/dining room. On the day of the inspection, a masseuse was visiting the home providing massages for people. We were also informed that they held DVD nights, BBQs and evening buffets with quizzes. One staff member told us, "We play board games, go out for coffee's and organise trips." The registered manager told us, "Engaging people with group activities is hard. We will organise trips but then people don't want to come. People will say they are bored, so we try and promote activities but then they don't engage."

The registered manager and staff acknowledged that due to the varying needs and ages of people, organising group activities was hard. Due to the varying ages and needs of people we queried how staff engaged with people and promoted meaningful activities based on what the person wished to do. One member of staff showed us a weekly planner they had devised with a person of what activities were meaningful to them, which included one to one support to go out and other things they enjoyed doing which were pertinent to them and their identity. However, this was not in place for everyone. For the younger people living at the home, we raised concerns on what level of engagement they were receiving. One person told us, "If it wasn't for the young staff, it would be hell." Where people were younger, we were unable to see what support they were receiving to engage with the community, people of their own age or do activities which would promote their confidence. One member of staff told us, "We have one person who's really interested in music and the internet. I'd like to get them more engaged with the internet and get them doing research on the internet to improve their concentration skills. We've also discovered some friends they have. We want to engage with their friends and try and encourage them to go out more regularly with their friends."

Lack of meaningful activities can increase the risk of social isolation and further the risk of mental health needs deteriorating. Lack of stimulation and engagement could mean people spend all day in their room or at the home. We observed that some people did spend all day in their room or at the home. On both days of the inspection, no activities took place; therefore most people spent all day smoking, watching television or sleeping. For people who were unable to go out unsupervised, we raised concerns about the structure of their day. The only structure provided was mealtimes, otherwise people spent all day at the home with no other means of stimulation. Staff members felt more work was required to engage people and do meaningful activities. One staff member told us, "We take out people, play board games but there could be more." Another person told us, "It would be good to have an activities coordinator, difficult with all other tasks to do activities as well." Documentation failed to reflect the level of support people received in accessing the community and ensuring the risk of social isolation was minimised. As weekly planners were not in place for everyone, we could not see if people received this input on a weekly or ad hoc basis. An activities book was in place which detailed the activities taking place. However, this was not completed on a daily basis and reflected that for weeks at a time no activities took place.

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story and their wishes. The care plans at Asher Nursing Home lacked any personalised information on the person. From the reading the care plans we were unable to gain any sense of the person, who they were, their likes, dislikes or anything about their history. Due to the mental health needs of people, there was also no information on what a normal day looked like for that person or how they perceived their mental health. Information was also not available on if their mental health deteriorated was there any treatment or

Requires improvement

Is the service responsive?

medication they would not want to be given. Staff members had a firm understanding of the personality traits of people, their likes and dislikes; however, this information was not reflected in the care plans. One staff member told us, “We have a good understanding of people. For example, one person can get really upset if they don’t have enough sugar in their tea, another person loves playing games on the computer.” Although staff had an understanding of people’s life history, care plans were not personalised to the individual. Information such as preferences is vital in recognising how people can remain in control of their life and regain a meaningful life despite living with a mental health need.

Due to the above concerns, in relation to the lack of meaningful activities and absence of person centred care plans, we have identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Communication in mental health nursing is an essential component of all therapeutic interventions and engaging with people with mental health needs. We asked people if they felt staff communicated with them and whether they felt listened to. People had mixed views about feeling listened to. One person told us, “I suppose so.” Another person told us, “Sometimes they do, depends. They listen if you do something wrong but I'd like a job one day, they don't listen to that.” Staff members told us people had a primary nurse who they could talk to and was responsible for coordinating their care needs. We asked people if they were aware of their primary nurse and felt confident talking to them. One person told us, “I don't know who my Primary Nurse is.” Another person told us, “I don't think my Primary Nurse has been here for a while.” The relationship between the primary nurse and person is an important one as the primary nurse is responsible for supporting the person and meeting their mental health needs. We raised concerns that people were unaware of their primary nurse and have therefore identified this as an area of practice that requires improvement.

There was information about how to make complaints in the form of a complaints procedure which was also contained in the service user guide. The complaints policy was also displayed in the entrance of the home. The policy contained the contact details of relevant outside agencies and the timeframe of when complaints would be responded to. Since the last inspection in September 2014, the provider had received two complaints. Information was available on the nature of the complaint, action taken and the outcome. Feedback was provided to the complainant and documentation was available on any investigation undertaken following a complaint and what learning had taken place.

Requires improvement

Is the service well-led?

Our findings

People and staff spoke highly of the registered manager. One staff member told us, "They've the best manager I've ever had." Another staff member told us, "Management sing from the same page." People felt the manager was caring and got along well with him. One person told us, "Yeah he's nice and ok." However, despite praise for management, we found Asher Nursing Home was not consistently well-led.

Documentation was in place for the recording of incidents and accidents. Information was recorded on the classification of incident (physical attack, verbal abuse, self-injury), who was involved, witnesses, what happened prior to the incident, during and after. However, information was not available on what mechanisms were in place to prevent the incident from happening again. For example, one person physically attacked a member of staff by scratching their hand. Documentation failed to reflect what strategies or mechanisms were considered or implemented to manage the person's behaviour or reduce the risk of any other physical attacks. Other incidences occurred whereby people were verbally abusive towards other people. The incident form included who was involved and what happened, however, information failed to reflect what further mechanisms were introduced to reduce the risk of any further incidences occurring. Whilst reviewing the incidences and accidences, we failed to see what oversight management had of incidences/accidents. An annual accident audit was completed which considered the number of falls, near misses, events reportable to RIDDOR and dangerous occurrences. However, the audit failed to monitor for any emerging trends, themes or patterns. Such as if people are falling at specific times or if incidences between people are occurring at certain times. Under the Care Act 2014, Providers and registered managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents. During the inspection, we could not identify what mechanisms were place to monitor incidents and accidents and the registered manager was only able to provide the annual accident audit.

Systems were not in place to monitor or analyse the quality of the service provided. The provider was not completing internal quality assurance checks to assure themselves and ensure they were meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regular health and safety checks were being undertaken but we were unable to locate any completed audits which related to the running of the home. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. We asked to see copies of the medication audit and care plan audit. The registered manager was unable to locate the medication audit but was confident the lead nurse had completed it. However, this could not be provided to us. We spoke with staff about the care plan audits. A care plan audit considers that the system for designing and implementing care plans is being used effectively, that care plans are up to date and of a good standard. Staff confirmed care plans were reviewed on a monthly basis but acknowledged they weren't completing care plan audits. We queried with the management team what systems were in place to review the effectiveness of the internal processes, clinical standards and the quality of the care and treatment. The registered manager told us, "I submit a weekly report to the area manager, hold staff and 'resident' meetings and get feedback from people." However, we could not identify what systems were in place to identify where quality or safety was being compromised and how to respond without delay.

Feedback from people was obtained on a regular basis. This was through the forum of resident meetings and satisfaction surveys. These provided people with a forum to air their views and provided opportunities for staff to contribute to the running of the home. The last resident meeting was held in June 2015, where national home care day was discussed, activities, wellbeing, behaviour and smoking. Satisfaction surveys were sent out to people on a regular basis. On a yearly basis, the provider analysed all results from satisfaction surveys providing an overview of the results. The analysis of the 2014 resident satisfaction surveys found that people felt staff treated them with respect and that they felt safe and secure. Although satisfaction surveys were analysed on a yearly basis, we were unable to find any analysis of satisfaction surveys in the interim, especially when negative feedback had been received. Satisfaction surveys had been sent out to people in February 2015 along with food satisfaction questionnaires. Where negative feedback had been received, we were also unable to see what action had been

Requires improvement

Is the service well-led?

taken. For example, some people had rated the quality of the snacks served between meals as poor. We were unable to ascertain what improvements had been made or if further investigation into the feedback had taken place.

Due to the above concerns, in relation to the quality assurance framework and acting upon feedback received from people, we have identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a management structure at Asher Nursing Home which provided lines of responsibility and accountability. A registered manager was in day to day charge of the home, supported by the deputy manager. In the absence of the registered manager, the deputy manager was in charge. On weekends, the management team provided on call support alongside the area manager.

Staff members spoke passionately about working for Asher Nursing Home and for the people they supported. Staff morale was described as "very good." One staff member told us, "The morale is very good here; we work as a team and get along well." Another staff member told us, "No day is the same, its challenging but worth it." From talking to staff members, it was clear they had a firm understanding of people's individual needs and had spent time getting to know people. Another staff member told us, "People's needs are catered for and staff remain calm." Staff members valued communication within the home recognising the importance of good communication. One staff member told us, "Handover's are really good and tell us what we need to know." Another person told us, "As soon as we come on shift we read the communication book and get informed of the important information."

There was a shared understanding by staff that teamwork was a key strength of Asher Nursing Home. One staff member told us, "We have a good core team here and due to this, we can adapt to the needs of people." Another staff member told, "We work really well together and that's important." It was recognised by staff and the registered manager that a key challenge and area they wished to improve on was moving people on.

Asher Nursing Home had recently participated in National Care Home Open Day. Care Home Open Day is a UK wide initiative inviting care homes to open their doors to their local communities. On this particular day, Asher Nursing Home opened its door to the public, inviting people to spend the day with them alongside building and promoting links with the local community. The registered manager had invited a local cricket player to open the day who also suffered with a mental health need. The registered manager told us, "I wanted someone involved in our community who suffered with a mental health illness to talk to people and engage people about mental health, so they were perfect."

On the first April 2015, the Care Quality Commission introduced the Duty of Candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager had a firm understanding of the Duty of Candour and following a recent incident whereby a person was administered the wrong medicine, the Duty of Candour was followed and the person was formally apologised to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA (RA) Regulations 2014 Need for consent** **The registered person had not ensured care and treatment of service users must only be provided with the consent of the relevant person. Regulation 11 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment** **Service users were not protected from abuse and improper treatment in accordance with this regulation. Regulation 13 (1)** **A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person-centred care 9 (1) The care and treatment of service users must be – (a) be appropriate, (b) meet their needs and (c) reflect their preferences. 9 (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) Carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

The enforcement action we took:
A warning notice has been served. The service is to be complaint within two months of receipt of the warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

The enforcement action we took:
A warning notice has been served. The service is to be complaint within two months of receipt of the warning notice.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good Governance** (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) Assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (e) Seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

The enforcement action we took:
warning notice has been served. The service is to be complaint within two months of receipt of the warning notice.