# Ashlea House
# Care Home Service

Bracklinn Road
Callander
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Telephone: 01877 330 325

**Type of inspection:**
Unannounced

**Completed on:**
26 March 2021

**Service provided by:**
Mauricare Ascot Care Limited

**Service provider number:**
SP2012011882

**Service no:**
CS2012310159

## About the service

Ashlea House is a care home for older people situated in the rural Stirlingshire town of Callander. It is owned by Mauricare Ascot Care Limited and is registered for a maximum of 21 older people. At the time of the inspection, 15 people were living in the home.

The home is an older property which has been extended. It is close to all amenities and transport in the town. The home is divided into three floors and access to all floors is by means of a lift.

Ashlea House state that their aim is to 'provide exceptional levels of care in smaller and more personalised care home surroundings as well as enjoying a relaxed, happy and friendly atmosphere.'

This was a focused follow-up inspection to evaluate how the service has responded to the Improvement Notice issued at the previous inspection during the COVID-19 pandemic.

This inspection was carried out by two inspectors from the Care Inspectorate.

## What people told us

People told us they enjoyed living in the care home. They felt well cared for and told us staff were kind.

## How good is our care and support during the COVID-19 pandemic?

This inspection was carried out to follow up on the Improvement Notice served to the provider on 19 March 2021. We found that whilst some improvements had been made, requirements were not met and further improvements were required. We extended the Improvement Notice and the provider must make the required improvements by 23 April 2021.

## What the service has done to meet any requirements we made at or since the last inspection

### Requirements

**Requirement 1**

In order that people's care and support can be provided in a person-centred and consistent manner during the COVID-19 pandemic, detailed summary care plans must be in place by 13 August 2020. This must include anticipatory care plans detailing people's palliative and end-of-life choices and wishes. Personal plans must also outline how people's health, welfare and safety needs are to be met. Evidence that people have been involved in developing the plan must also be included.

This is to ensure that care and support is consistent with the Health and Social Care Standards, which state that: 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices.' (HSCS 1.15) and to comply with Regulation 5 - Personal Plans of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

**This requirement was made on 16 July 2020.**

#### Action taken on previous requirement

People's care plans were being reviewed and new support plans were in place. Support plans were person-centred and demonstrated a clear understanding of people's needs. These examples could be used as templates to increase staff's understanding and skills and improve the quality and efficacy of people's care plans.

Assessments of risks to residents were beginning to be introduced but this was as a result of feedback from visiting professionals. Assessments did not always identify why people were at risk. For example, risks of choking were perceived to be caused by eating too quickly rather than problems with swallowing. Consequently, risks were not appropriately addressed and people continued to be at risk of harm.

Although referrals to external professionals had improved, we identified that gaps remained. For example, the communication needs of people with learning disabilities and people living with dementia were not recognised and referrals for support were not made. People continued to be at risk of emotional and psychological harm and social isolation.

People's needs were being assessed using a tick box format with little or no narrative to explain the findings. There was no explanation of the rationale used to assess people's needs and reviews did not evaluate the care and support provided to ascertain whether people's needs continued to be met. We were not assured that people's needs were appropriately assessed, met or reviewed.

Communication systems such as handovers and daily short meetings were poorly recorded. We could not find evidence that staff were provided with information about risks or changes to people's needs. Quality assurance audits were not carried out regularly and did not identify or address areas for improvement. We noted changes in people's health and welfare needs recorded in daily care notes were not recognised or responded to appropriately. Care plans were developed by nursing staff. Care staff told us they did not have the opportunity to read or contribute to care plans. Therefore, new care plans were not implemented by care staff.

Training was provided by external professionals in relation to assessing and managing pain and supporting people experiencing stress and distress. Information and guidance provided at the training was not shared with staff unable to attend.

These concerns put the health, safety and wellbeing of people at risk.

Outcomes for some people had improved but this was as a result of the input of external professionals. Improvements must be identified and driven by the provider if they are to be sustained.

**Not met**

### Requirement 2

In order to ensure people's pain levels are recognised, assessed and managed appropriately, the provider must put in place effective pain management procedures by 30 November 2019.

This is to ensure care and support is consistent with the Health and Social Care Standards, which state that: 'My care and support meets my needs and is right for me.' (HSCS 1.19), and in order to comply with Regulation 4 - Welfare of Users of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

**This requirement was made on 23 October 2019.**

**Action taken on previous requirement**

There was evidence that outcomes for some individuals had improved because of increased involvement from external professionals, medication reviews and improvements in staff practice. Some staff felt more confident in recognising how people could present when they were in pain. Nurses confirmed this was reported to them more promptly. This meant that the risks for some people of experiencing distress due to pain was reduced.

Pain assessment tools had been introduced but there was no written guidance to support staff. This impacted upon their knowledge, confidence and use of the tools. Care staff were not familiar with support plans or tools appropriate for use with people living with advanced dementia or other cognitive impairments. Consequently, people risked experiencing on-going, unresolved pain.

Pain management care plans were not in place for all people who were known to have a high risk of pain. These plans provide guidance about possible causes of pain, how people expressed pain or interventions to manage pain without medication. The staff responded and introduced new plans when advised, but there was no system in place for this to be progressed. This meant we were not assured that people's needs were effectively met.

Palliative care learning sessions were being provided by an external professional. There was no system to check staffs understanding of what they had learned or the changes they had made in practice. There was no formal process for sharing the learning with staff unable to attend. Therefore, not all staff had the knowledge and skills required to improve upon how people's needs were assessed or evaluated. This had a detrimental impact upon people's quality of life and led to poor outcomes.

It is of concern that improvements made are in response to direct feedback from Inspectors and other visiting professionals. There is little evidence of internal quality assurance systems that are driving forward change and improvement.

**Not met**

## Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

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