Four Seasons Health Care (England) Limited

Ashcroft Nursing Home - Chesterfield

Inspection report

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Date of inspection visit:
06 February 2018

Date of publication:
27 March 2018

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

We inspected this home on 6 February 2018, this was the homes first inspection since their registration in March 2017. The inspection was unannounced Ashcroft Nursing Home in Chesterfield is a residential nursing home. People in care homes receive accommodation, nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate up to 42 people. At the time of our inspection there were 31 people living in the home.

The home had a registered manager 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 2008 and associated Regulations about how the home is run.

People were supported to have maximum choice and control their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice. Staff received support for their role and training to develop their level of understanding about the care they provide.

People and their relatives felt relaxed at the home. All the staff were passionate about providing a home that met people's needs. Relatives told us that their family member received care which was compassionate, kind and respectful.

People were protected from harm and staff knew to raise any concerns. Any concerns raised had been investigated and lessons learnt how to avoid a reoccurrence. The control of infection had been managed and people were encouraged to personalise their own space. The home continued to make improvements to the environment both internally and in the garden.

There was sufficient staff to support people's needs and they had been recruited using appropriate checks to ensure they were suitable to work with people. The meals provided a variety of choices to support people's dietary needs. Medicines were managed safety and in line with peoples prescribed needs.

Stimulation was on offer which supports people's interests or previous lifestyles. The care plans were detailed and included all aspects of peoples care. These had been reviewed and any changes reflected.

A range of information was available to relatives and visitors, these included a complaints procedure. Any complaints had been responded to formally. The home completed regular audits on a range of areas to ensure the quality of the care was maintained and improved. Feedback was obtained from people using the home and staff members, information from the surveys had been shared to reflect the comments and actions to consider the feedback.

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

Staff were trained to protect people from abuse and harm.

Risk assessments were centred on the needs of the individuals.

There were sufficient numbers of staff to meet people's needs, and the staff were recruited appropriately.

The provider managed the control of infections and the safe management and administration of people's medicines.

Is the service effective?

Good

The service was effective

Staff had received the training they needed to meet the needs of people.

The registered manager understood their responsibilities when people lacked the capacity to make decisions.

People had been supported to maintain and improve their healthcare needs. Meals were varied and provided a choice for people which met their dietary needs.

The home was decorated and people could add their own personal touch to their rooms.

Is the service caring?

Good

The service was caring

The staff had established positive relationships with people.

People's dignity was respected and maintain with all aspects of care.

People were supported to maintain their relationships and visitors were welcome.

Is the service responsive?

Good

The service was responsive

Peoples preferences had been identified to ensure their needs were supported..

Stimulation was on offer which reflected individual's lifestyles and interests. There was a complaints procedure in place, and any concerns raised had been addressed.

People receive care and support in a dignified way when they were coming to the end of their life.

Is the service well-led?

Good

The service was well-led

The home was run by a registered manager, they were accessible and had a visual presence in the home.
Audits had been completed to reflect changes required and to drive improvements.
People's views had been obtained and any suggestions acknowledged and responded to

Ashcroft Nursing Home - Chesterfield

Detailed findings

Background to this inspection

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

This inspection took place on 9 February 2018, and was unannounced. The inspection team consisted on two inspectors. This was the providers first inspection under their current registration with us.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us at the inspection visit. We also checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We reviewed the quality monitoring report that the local authority had sent to us. All this information was used to formulate our inspection plan.

We spoke with three people who used the service and six relatives. Some people who used the service were not able to have a conversation with us due to their complex needs and limited verbal communication skills. We therefore spent time observing how staff interacted with people who used the service. We watched how staff supported people and cared for them. We did this to understand people's experience of living at the service.

We also spoke with five members of care staff, the cook, the nurse, a CHAP (Care Home Assistant Practitioner) and the registered manager. The regional manager was also present for the inspection. We looked at a range of information, which included the staff training records, and care records for four people

who used the service. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored, these included audits relating to medicines, the control of infection and the ongoing improvements to the home.

After the inspection we asked the registered manager to provide us with some additional information with regard to information access and information relating to care and support for people end of life. We received this information and have included it in the report.

Good

Is the service safe?

Our findings

Relatives felt their family were safe through the care provided at the home. One relative said, "They are safe, I feel I can walk away happy and know they are in good hands." Staff had received training in protecting people from the risk of harm and understood the different possible signs of abuse around safeguarding and how to raise a concern. Staff we spoke with knew how to recognise and report abuse; this included relevant external authorities when required. Information was displayed openly in the main reception area of the home for people, staff and visitors told us they knew how to recognise and report abuse.

When people had fallen their safety was reviewed and measures put in place to reduce the risk of people falling again. For example, sensor mats, which alerted staff when someone moved to inform the staff there maybe a risk the person could fall. The registered manager told us they had invested in portable motion sensors. These were as a result of lessons learnt at the home following other equipment not being effective enough. The registered manager said, "The motion sensors are able to be transferred with the person from seat to seat." This showed the provider took action to learn from situations and seek solutions when needed.

Some people were reluctant to wear shoes; however they enjoyed walking around the home. A family member told us, "We have tried everything, different slippers and the slipper socks but they will not keep them on." The registered manager was aware of some people at risk in this way and staff knew how to maintain their safety. Staff we spoke with identified they keep areas clear and domestic staff were aware of the safety in relation to wet floors. We saw risk assessments identified any areas of concern and solutions.

Some people required equipment to support them to transfer. We observed staff providing this support and it was done with care and reassurance. One relative said, "The staff are very caring and take their time with the equipment." We saw some people were at risk of choking. For these people they had received assessments from health professionals. A family member said, "I used to assist [name] but now they are a high risk of choking so the staff have taken this responsibility and provide one to one support for mealtimes." Some people required pressure care and we saw this was provided and recorded. This included care to people's fingers and nails to avoid people receiving sore skin from the pressure of their nails on their palms. This meant that risk assessments identified areas of concerns and guidance or action to take to reduce the risks.

The home had a full time maintenance person who ensured all the homes checks were completed and that when items broke they were repaired quickly to ensure people's safety was maintained. For example, a remote control to a profiling bed had broken; a new one had been ordered and the broken one fixed temporarily. The maintenance person told us, "If I need anything I can get it straight away." People had a personal evacuation plan, which identified the support a person would need in an emergency. Staff understood how to evacuate people and they had received training in this area.

There were sufficient staff to support people's needs. One relative said, "There are usually enough staff and always someone in the lounge area." We saw that two people had one to one care staff support. This was

provided by agency staff. They told us, "It's usually a small team, I am a regular here." We saw another person had been allocated one to one support for their social needs and this was provided. The provider had a dependency tool which reflected the needs of people using the home. This helped to inform the levels of staff and was reviewed on a regular basis or when either people's needs changed or new people joined the home.

When staff commenced their employment the provider had carried out checks to ensure that the staff who worked at the home was suitable to work with people. This included references and the person's identity through the disclosure and barring service (DBS). The DBS is a national agency that keeps records of criminal convictions. The records we checked showed all the required checks had been completed. This demonstrated that the provider had safe recruitment practices in place.

We observed staff administering people's medicines. People were given a drink and time to take their medicines whilst the staff member stayed with each person to ensure they had taken their medicine before recording this. All the staff required to give medicines had received training in medicine administration and their competency was reviewed. We checked the storage of medicines and how the stock was managed. When people had received their medicine we saw that medicine administrations records had been completed. These were reviewed as part of the registered managers auditing process. Some people required pain relief on an as required basis, due to many people being unable to verbalise their wishes clearly the 'Abbey pain scale' was used to evaluate people's pain and symptoms. We saw the information about people's medicine was included in their care plans with any known allergies or elements which needed to be considered for their prescription. This meant staff would be aware of any risks relating to their medicine.

The provider had worked with local healthcare commissioners following their recent audit of people's medicines at the service. The audit was positive and only identified some minor recommendations for improvement. We saw the registered manager had already tasked the nursing staff with completing the improvements and the nursing staff were aware of the actions and timeframe to achieve this.

Relatives told us they felt the home was kept clean. One relative said, "The home is always clean and never smells." We saw staff followed cleaning schedules to reduce the risk of infection. Staff used aprons and gloves when they provided personal care or when handling food. The home had received the top five star rating from the food standards agency. The food hygiene rating reflects the standards of food hygiene found by the local authority.

Good

Is the service effective?

Our findings

People received care that was in line with good practice guidance to support their individual health needs. For example, some people were living with diabetes. Guidance in care plans ensured that nursing staff followed these to administer the correct levels of insulin. The person's blood sugar was checked to ensure the correct levels of insulin were provided. Care staff knew the signs to be aware of if the person became unwell and the action to take. This meant people received the treatment in line with current legislation and best practice.

Appropriate referrals had been made to health care professionals for people's care and treatment when required. For example, one person had been seen by a skin specialist. This person required specialist cream to be applied and follow up appointments. We saw this information had been updated in the care plan and staff had followed the plan. The relative for this person told us, "The staff has been very good and they will take them to the appointment if I am not available." One person explained they often felt fearful and anxious because of their health condition, but felt that staff helped to keep them safe. Other relatives told us and we saw other health care professionals had been consulted to support peoples ongoing wellbeing and health.

Staff had received training for their role to enable them to meet people's needs. One staff member said, "We are always learning here, with formal training, discussion and information sharing." They went on to tell us, "Recently I had learning about how an infection can affect people's mood, so now I know how to spot the signs and report quickly. Things are then dealt with more promptly."

Staff felt supported by the registered manager. One staff member told us how they had utilised staff skills. They told us, "I have completed a university degree and my dissertation was on reminiscence therapy. I was able to utilise this here at Ashcroft Care." We saw staff received support with their ongoing nursing registrations and new training. One staff member planned to commence their nurse training; they had been shadowing the registered manager on new admission assessments to help increase their related knowledge and understanding. They told us, "That kind of support makes all the difference."

Staff had been promoted and supported with the development of their role. One staff member told us, "Training and support is very good. In my new role I was supernumerary for the first two weeks and I have completed the provider's deputy manager programme." This showed that the provided supported staff to develop their skills for their role.

People and relatives told us they enjoyed the food at the home. There was a choice of meals and these were displayed in writing on a black board along with a pictorial guide to assist people in making a choice. The registered manager told us, "This is an area we are developing so we can have more pictures available and menus on the tables; this will support people's choices." The cook understood people's dietary needs and was informed about any changes. Some people had been referred for a speech and language assessments, following concerns raised when people's weights had reduced or they lacked an appetite. We saw when guidance was provided this was shared with staff and the cook to ensure people received the correct level of support. We saw during the morning and afternoon tea breaks people were provided with a choice of

snacks. Some snacks had been fortified with calories to support those people who had been identified as being at risk of weight loss or requiring additional nutrition. At lunchtime and teatime people were encouraged to sit in the dining room for their meal. Relatives told us, "It's a good idea as it gets people moving and encourages some social contact." People were given this as a choice and if they chose to stay in the lounge a staff member remained with them.

People were able to personalise their own rooms. For example, one relative told us the maintenance person had put up a shelf so they could put family photos in their relatives room. Ashcroft Nursing Home had a bright and homely feel and had been redecorated over the last year. The registered manager told us the next area to be decorated was the corridors. As there were four main corridors they were to be themed in line with the seasons. Consideration would be made in relation environmental guidance in relation to people living with dementia .People were able to access the outside space and it was secure.

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

Staff we spoke with understood and followed the principles of the Act. Staff were observed seeking people's consent before they commenced their support and care. We saw staff gave people choices and encouraged people to make a decision with prompts and visual clues. For example, with drinks and meals. Staff understood about when a DoLS was required and when it had been authorised. One staff member said, "There's a list in the office and we get this information through staff handover's and the daily flash meetings."

Where needed people had mental capacity assessments in place which described what decisions they could make. For example, we saw that people had capacity assessments in relation to the use of equipment and medicines. For some people who lacked capacity to make decisions, we saw that best interest meetings had been completed and the appropriate people had been consulted. The registered manager had a clear understanding and ensured that DoLS applications were reviewed and any outstanding applications were monitored.

Good

Is the service caring?

Our findings

Relatives felt the staff genuinely cared about their relative at the service. One said, "They truly are genuine in how they care for people." Another said "They have compassion and try to interact with people as best they can."

Staff provided people's care in a way which showed their understanding of the person. For example, staff told us about one person who could easily become upset, anxious and cross when they didn't understand what was happening around them. We saw when this started to happen, staff noticed straight away and provided gentle reassuring distraction by engaging the person in singing, which they knew the person enjoyed. This person engaged in this way and became more visibly relaxed and contented.

Staff used information about people to support them to express their views or make decisions about their day. For example, we observed staff strike up a conversation about the geographical area one person had come from and this generated a lively chat between the care staff and the person. People had been encouraged to make decisions about their choice of dress styles. Some people were wearing jewellery and others clothes reflective of their choice. Relatives told us, "[Name] is always clean and well presented."

We saw that those relatives and friends important to the person had been included in the development of the care plan and ongoing needs. One relative said, "The staff contact me if there are any concerns or changes or when a health professional has been." Other relatives told us they felt welcomed and relaxed at the home. One relative told us," I come regular, you are always made welcome." Another relative said, "The staff are nice and friendly and approachable if you need to ask them anything."

People's privacy and dignity was promoted and respected. Relatives we spoke with felt the staff showed respect to people. One relative said "They make sure people are dressed appropriately and knock on bedroom doors; things like that and speaking to the person by name." Another said, "Staff are always respectful, kind and welcoming here." We saw that staff ensured they were discreet when supporting people with their personal care needs. Staff knocked the doors before entering bedrooms and bathrooms.

Staff told us they had received training in dignity and it was a regular focus at staff meetings. Some staff had taken on the role as dignity champions; they supported key aspect within staff meetings to continue to promote dignity within the home.

Good

Is the service responsive?

Our findings

People and those important to them had been involved in identifying their needs which informed their assessment and care plans. One relative told us, "I have been involved in talking about their needs to support the care plan." Another relative told us, "I have been involved for many years. I have a meeting every two months for my own peace of mind. It means we keep things up to date." We saw the care plans provided individual aspects to peoples care. For example, the name the person prefers to be called or their individual preferences relating to meals, relationships and lifestyles. Observations and our conversations with staff supported this approach.

The provider used an electronic tool on an iPad for staff to follow when completing people's care plans. Staff told us the information on the iPad provided guidance and prompts . One staff member told us, "It supports you through all the areas you need to cover, like emotional and psychological care." The information then translates into a personalised care plan for each person. One staff member said, "Anything new learned about a person to help us provide the right care; we always share in the daily flash meetings, no matter how small a piece of information." A 'flash meeting' is a term used by the provider when a short meeting is held to reflect information in relation to the care to support people's needs.

Before people commenced their stay at the home they received an assessment of their care needs. This was to ensure the home was able to meet the person's care and daily living needs. The registered manager told us, "We are careful that the admission is planned and we can accommodate people. We also have to consider the other people already living here."

Staff received training in equality and diversity; staff told us how it had raised their awareness. One staff member said, "It removes the taboo of the subject and makes you consider the question and not make assumptions." We saw the staff were working on developing this within the care plans. Some areas had already been considered which reflected people's lifestyle preferences and life history.

We saw that some information was available in easy read formats. For example, the complaints information was provided in a flow chart format and was presented in a different colour to the other leaflets. The provider also had a policy which reflected that on requested other formats would be provided to people. These included large font size and alternative languages. To date none of these had been requested.

Staff received a handover when they commenced their work shift; this is referred to as the 'flash meeting'. This provided information relating to peoples current needs. One staff member told us at the daily 'flash' meetings they receive information relating to known risks and reduction measures. For example, staff told us about the action they had taken when one person had been found on the bathroom floor. Staff told us, "They were not known to fall so we provided regular checks and recorded the situation to support any required assessments."

People had access to social and occupational activities to keep them stimulated. One relative said, "It's lovely to see people doing things." There was a designated activity person, however staff told us when the

activities staff was not available they all took time to provide some activities. During the inspection various activities were delivered which were suitable for the people who wished to participate. We also saw that staff were flexible to change an activity when people were not being responsive or requested a different activity. The subsequent activity organised was received more favourably and we saw people responded to this and enjoyed the event, showing smiles and participation.

The provider had considered people's individual's lifestyles and how these could be incorporated within people's daily living arrangements. For example, one person used to be a farmer and their family planned to bring in some hay bales so they could continue with some of the tasks they associated their farming days. The staff told us this would entail the person and the handyman carries the bales from one end of the garden to the other. Another person enjoyed shopping. We saw how a scooter had been purchased so the person could be independent, but be accompanied by staff when they went out. The person had been assessed by a health care professional to ensure they were safe to use the scooter.

There was a complaint procedure displayed in the reception of the home. We saw that when complaints had been raised they had been addressed in line with the policy timeframes. All complaints had been investigated and meetings held with the relatives to clarify any concerns. These meetings and the outcome of any investigation was formally communicated to the complainant. One relative who had raised a complaint told us, "I feel my complaint was dealt with very effectively and the investigation was completed by someone from another home. I received a formal response and felt satisfied with the outcome." Other relatives told us they had raised niggles and these had always been addressed. This showed the provider was open and transparent with any concerns and acted to resolve them.

People had been supported about preferences for their end of life care. We saw that one person was receiving care and their needs were addressed through a care plan approach which included their equipment, comfort and pain relief. Related medicines, known as 'anticipatory medicines' had been obtained for their end stage care. This helped to avoid their unnecessary hospital admission and support the person's known wishes to remain at Ashcroft Nursing Home. Family and friends had been kept informed about the person's progress and care being provided for them. The person had received regular support from the GP practice. We saw thank you cards which reflected the level of care people had received at this difficult time and how staff had been responsive and ensured the persons dignity was maintained.

Guidance was provided as to how to maintain the persons comfort and reduce any unnecessary sore skin. Some staff had received end of life training, and the deputy manager had previously worked in a hospice and had shared their knowledge with staff. When staff required additional support they were able to obtain this through the palliative team via a referral or a direct helpline. After the inspection we asked the registered manager to share with us some additional information, these included the provider's policy, training and information. We received this information which provided us with further assurances in relation to this area of care.

Good

Is the service well-led?

Our findings

Ashcroft Nursing Home has a registered manager. 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 2014 The registered manager understood their registration and had ensured we had been notified of any events or incidents which had occurred at the home.

Relatives and staff all felt there was a homey atmosphere. One relative said, "It's very welcoming. It can be frantic with all these people, but that shows their personality." One staff member said, "It's a great place to work and we are a good team."

The manager was supported by the provider. They had a regional manager who was available for support and they also attended managers meetings to obtain reflective support from other managers and the providers other locations.

There had been a meeting for people who use the service. This meeting discussed the activities people wished to be organised and the meals they received. These were reviewed by the registered manager and actioned to ensure the voice of the people was followed through in to providing the care they had identified. We saw a care survey had been completed by the provider with people who use the home and the outcome displayed on the notice board, we noted these were overall positive responses. The provider had also provided a survey to all their staff about their working arrangements. We saw the feedback from this was incorporated into a leaflet along with the home reviewing and setting up an action plan to address the comments.

The manager had regular meetings with different staff leads within the home. For example, the registered manager met with the maintenance person to reflect on the health and safety for the home. At a recent audit it was identified some equipment was replaced when its usage date had expired, for example eye baths and we saw these had been replaced.

Other audits had been completed to drive improvements. For example, the infection control audit found concerns in relation to standards of cleanliness at the service. We saw how management measures had been implemented from this over the last few months through revised cleaning schedules and the provision of additional cleaning equipment. For example, a steam cleaner had been purchased for floor cleaning in communal areas instead of water mopping. This helped to reduce the risk to people from slips and falls. Scores achieved on subsequent audits showed improvements were made. This meant related management measures implemented had been effective and being followed by staff

Audits relating to when people had fallen had been reviewed on a monthly basis. These reflected any trends and considered what action could be taken to reduce the risks of further falls. We saw equipment, like beds which could be adjusted to different heights were in place and the assurance that a staff member was always available within the lounge. Staff had also completed falls prevention training. One staff member

told us, "It was useful; I now have a better understanding of risks and preventative measures." They went on to provide some examples, "Ensuring a clear environment to reduce a trip hazard, people wearing proper foot wear or not slip type socks and prompt cleaning of spillages." This showed the provider took an active approach to reduce the risks for people.

Partnerships had been established with a range of health care providers to support the care to people. These included chiropodists, consultants in relation to people's specific conditions and other professional's dependant on individual's needs. This meant that people would be supported by a range of professional to consider the care they required when their needs changed.